Part IA – Technical Proposal

Response to
Request for Proposal
RFP 3491

State of Nevada Purchasing Division

External Quality Review Organization (EQRO)

February 22, 2018
2:00 p.m. PST

Health Services Advisory Group, Inc. • 3133 East Camelback Road, Suite 100 • Phoenix, Arizona 85016
Phone: 602.801.6600 • Fax: 602.801.6051

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RFP Title:	EQRO
RFP:	3491
Vendor Name:	Health Services Advisory Group, Inc. (HSAG)
Address:	3133 E. Camelback Road, Suite 100 Phoenix, Arizona 85016
Opening Date:	2/22/18
Opening Time:	2:00 P.M.

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Section III – Vendor Information Sheet

VENDOR INFORMATION SHEET FOR RFP 3491

Vendor Shall:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 shall be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Section III of the Technical Proposal.

V1	Company Name	***Health Services Advisory Group, Inc. (HSAG)***
V2	Street Address	***3133 E. Camelback Road, Suite 100***
V3	City, State, ZIP	***Phoenix, Arizona 85016***

V4	Telephone Number		
	Area Code: ***602***	Number: ***801.6600***	Extension:

V5	Facsimile Number		
	Area Code: ***602***	Number: ***801.6051***	Extension:

V6	Toll Free Number		
	Area Code: ***877***	Number: ***601.6050***	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: ***Mary Ellen Dalton, PhD, MBA, RN***
	Title: ***President and Chief Executive Officer***
	Address: ***3133 E. Camelback Road, Suite 100, Phoenix, Arizona 85016***
	Email Address: ***mdalton@hsag.com***

V8	Telephone Number for Contact Person		
	Area Code: ***602***	Number: ***801.6701***	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: ***602***	Number: ***801.6051***	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: ***Mary Ellen Dalton, PhD, MBA, RN***	Title: ***President and Chief Executive Officer***

V11	Signature ***(Individual shall be legally authorized to bind the vendor per NRS 333.337)***	
	Signature: Mary Ellen Dalton	Date: 2-15-18

Section IV – State Documents

A. The signature page from all amendments signed by an individual authorized to bind the organization.

A AMENDMENTS

The signed signature pages from all amendments can found beginning on the following page.

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 1to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 2, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

RFP CHANGES:

1. Old language:

2.2.5 As described in (described in §438.310(c)(2)) an EQRO may not:

New language:

2.2.5 As described in (described in §438.**354**(c)(2)) an EQRO may not:

2 Old language:

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

New language:

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR **438.358**(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

3. ***RFP section deletions:***

RFP Section 2.2.9 to be deleted in its entirety.

4. ***RFP ATTACHMENT G – COST PROPOSAL REVISED:***

Vendors to submit cost on the following revised cost proposal:

EQRO Cost Sheet
Revised 2.1.18.xlsx

QUESTIONS AND ANSWERS:

1. Vendor Duties and Responsibilities-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings to be priced by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in prior RFPs?

   Yes, the Cost Schedule will be amended to include web meetings, teleconferences, and face to face meetings.

2. 2.1 and Attachment G – Cost Schedule-2.1.5.4.A, B, C-12 and 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

   Refer to the beginning of this amendment. Attachment G has been revised.

3. Attachment G – Cost Schedule--41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP

consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

Refer to beginning of this amendment for RFP submittal change.

4. Attachment G – Cost Schedule--41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

Refer to the beginning of this amendment. Attachment G has been revised.

5. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Are there current contract requirements or other guidance for the MCOs and PAHP for Network Adequacy?

There are current network adequacy standards outlined in the MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

6. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-What are the current network adequacy standards for the MCOs and PAHP?

Refer to MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

7. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Has the State of Nevada developed the new managed care requirements, related to time and distance standards, format for annually certifying adequacy of their networks?

Refer to MCO RFP 3260 Section 3.6.3.2. Twenty-Five Mile Rule.

8. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Does Nevada contract with MCOs or PAHPs for long term services and supports?

Refer to MCO RFP 3260 Section 3.4.4.2 Excluded Populations, Services and Coverage Limitations for Individuals Enrolled in Managed Care. The DHCFP does not contract with the DBA for adult dental services.

9. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-Please clarify who would be conducting these PIPs?

The selected EQRO vendor may be asked to conduct PIP activities in addition to the validation of MCO PIP activities.

10. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-What is the EQRO's role with PIPs in addition to those conducted by health plan?

The EQRO's role would be to validate additional PIPs conducted by the PCCM/CMO related to Pay for Performance Measures (P4P).

11. 7-2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are the HEDIS measures?

    The State does not understand this question. Is the vendor looking for a list or an amount of the HEDIS and non-HEDIS measures?

12. 2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are not HEDIS and will be validated using the CMS protocol?

    Refer to the response provided in question 11.

13. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for whether the PIP topics are selected by DHCFP, the MCO or the EQRO?

    Historically, the DHCFP has collaborated with both MCO and EQRO vendors to determine PIP topics based from performance measure data for the MCO vendors.

14. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for the selection of a single PIP topic across all MCOs or for allowing MCOs to select distinct and separate PIP topics?

    The DHCFP has had the same PIPs across plans as well as selected distinct and separate PIPs. PIP selection is determined by performance indicators, as well as determined with Nevada Department of Health and Human Services health goals and objectives in mind.

15. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-If the MCO is allowed to select the PIP topic, is the topic vetted and approved by DHCFP or the EQRO before implementation?

    Yes.

16. 2.1.3.5-Validation of the Nevada DHCFP State QAPIS in SFY 2019 and each subsequent EQR contract renewal year; page 9-Can the state provide more detail about what data or documents the EQRO might review as part of the QAPI to measure objectively the progress and status of Value Based Purchasing?

    Validating performance measure data related to pay for performance programs outlined within CMO, MCO, or DBA contracts.

17. 2.1.4-Compliance Review; page 10-How many sections are in the compliance review?

IQAP Compliance Review Calendar		
Standard Number	Compliance Review Standard	Review Year
I	Internal Quality Assurance Program	**FY 2020**
II	Credentialing and Recredentialing	**FY 2018**
III	Member Rights and Responsibilities	**FY 2019**
IV	Member Information	**FY 2019**
V	Availability and Accessibility of Services	**FY 2018**

VI	Continuity and Coordination of Care	**FY 2019**
VII	Grievance and Appeals	**FY 2019**
VIII	Subcontracts and Delegation	**FY 2018**
IX	Cultural Competency Program	**FY 2020**
X	Coverage and Authorization of Services	**FY 2019**
XI	Provider Dispute and Complaint Resolution	**FY 2018**
XII	Confidentiality and Recordkeeping	**FY 2020**
XIII	Provider Information	**FY 2018**
XIV	Enrollment and Disenrollment	**FY 2020**
XV	Program Integrity	**FY 2020**

18. 2.1.5-Technical Assistance and Optional Activities; pages 10-11-Can you clarify whether cost information for the Technical Assistance and Optional activities described in Section 2.1.5 is requested for the Cost Proposal at this time; or whether it should be provided after a specific request and scope of work is provided by DHCFP (as indicated at the end of 2.1.5)?

    After a specific scope of work and request for costs is provided by the DHCFP.

19. 2.2.9-ICD-9 and EDI compliance; page 14-Section 2.2.9 indicates the vendor must maintain ICD-9 and EDI compliance as defined by CMS. Could the state cite the CMS regulations to which this compliance refers?

    Refer to beginning of this amendment for RFP submittal change.

20. 2.4.1-Implementation; page 15-Is a preliminary work plan required as part of the proposal?

    A preliminary work plan is not required as part of the RFP.

21. 9.2-Proposal Evaluation and Award Process, page 28-Is there a state statute, regulation or written rule that describes in more detail the specifics for the 5% discount for Nevada-based businesses? If not, can DHCFP elaborate on the criteria used to determine the 5% discount?

    Refer to Assembly Bill 280 dated March 13, 2017.

22. 7.-RFP Timeline; page 21-Is there a meeting of interested bidders prior to the submission of the bid?

    No.

23. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-Are there instructions on preferred response content for the Scope of Work sections?

    The State has no additional instructions. The State will accept a clarifying question.

24. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-The instructions indicate that the vendor shall place their responses to the technical sections immediately following the applicable RFP question, statement, and/or section. Does this mean that the vendor must respond to every section/subsection individually or can sections/subsections be combined where it makes sense?

Vendors shall respond to the Scope in its entirety.

25. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -The cost spreadsheet has citations that are supposed to be directed back to the RFP, but they are missing digits. For example, on the first line of the spreadsheet for the Activity of Performance Improvement Project Validation, one of the citations is 2.3.3. We cannot find a 2.3.3 in the RFP.

    Refer to beginning of this amendment for RFP submittal change.

26. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, under Optional Activities, there is an Activity for Consulting. The citation is 2.5.6, but there is no 2.5.6 in the RFP. We believe it references Section 2.1.5.6 regarding consulting, however there is no scope of work (SOW) for that. In fact, this page (12) implies that a SOW would be submitted in writing from the state after the contract is awarded to the EQRO so that the EQRO may submit a cost proposal at that time. Can the state provide details for the consulting work if it is intended to be part of the cost proposal for this RFP?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

27. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, can you clarify which Optional Activities that you expect proposed cost for at this time?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

28. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are you requesting hourly rates?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

29. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are these sections to be completed once a final vendor is selected and scope of work is provided?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

30. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of plans that would undergo a Performance Measure Validation audit?

    3 MCOs, 1 DBA, and 1 CMO.

31. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of HEDIS and non-HEDIS measures that it will require each of the entities to report or a maximum number of performance measures to be validated?

    MCOs- 26 HEDIS measures (9 hybrid measures).
    DBA- 1 HEDIS measure, and 3 non-HEDIS measures.
    CMO-22 HEDIS like measures.

32. Section 2.1.3, Scope of Work, page 8. Can the State clarify the number of hybrid measures that is expects each entity to report on?

Refer to the response provided to question 31.

33. Section 2.1.3, Scope of Work, page 8. Can the State clarify its expectations for the timing of performing the performance measure validation audits?

The start of this activity usually begins in January and the final audit report is presented in July.

34. Section 2.1.4, Scope of Work, page 10. It states "Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually." Can the State clarify as to what is meant by "broken out into sections to be reviewed annually"? What sections must be reviewed in SFY19?

Refer to the response provided to question 17.

35. Section 2.2.8 Qualifications of External Quality Review Organizations, page 14. Can the State clarify why an NCQA-Certified Health Employer Data Set (HEDIS) Compliance Auditor is a required position if the validation of performance measure activity can be conducted using the Centers for Medicare & Medicaid Services (CMS) Validating Performance Measure Protocol, which does not require the use of an NCQA-Certified HEDIS Compliance Auditor?

State choice.

36. Section 9, Proposal Evaluation and Award Process, page 27. RFP indicates "Conformance with the terms of this RFP" carries a weight of 10%. Does the submission of modifications/exceptions to the contract terms and conditions have any impact on the scoring of the vendor's proposal?

The evaluation committee may take into consideration any modifications/exceptions when scoring.

37. Section 9.8, part of Proposal Award and Evaluation, page 28. This section indicates "A Letter of Intent (LOI) shall be issued in accordance with NAC 333.170 notifying vendors of the State's intent to award a contract to a vendor, pending successful negotiations." Is the LOI sent directly to all vendors or posted on the website or provided in a different way?

The LOI only goes to the proposing vendors.

38. Section 10, Terms and Conditions, page 29 and Attachment C, Contract Form, page 37. Is the State willing to negotiate the terms and conditions of the contract? If yes, where should vendors include contract modifications/exceptions, e.g., attachment to cover letter, appendix of RFP response, etc.?

No.

39. General Question. Please provide the names of vendors who submitted questions. If the State is unable to provide the names, please provide the number of vendors who submitted questions.

Health Insight Assure, LLC; HSAG.

40. General Question. Health Services Advisory Group (HSAG) is the incumbent. What is the annual contract value and hours in their current contract? Is the scope of work requested in this RFP substantially similar to the current work being provided by HSAG?

The scope of work outlined within the RFP is similar to the current HSAG contract with the exception of some of the optional activities listed, as the DHCFP has potential to include the activities, but forward movement related to expanding coverage of the managed care populations and service areas has not yet been solidified.

41. General Question. What is the maximum budget for this project?

The State chooses not to disclose this information.

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

43. 2.1.3.2-8-Can the vendor subcontract with a Certified HEDIS Compliance Auditor to conduct the validation of performance indicators task or is a NCQA licensed organization required?

Refer to RFP 3491 Section 2.2.8.

44. 2.1.3.2.A-8-Does DHCFP currently require submission of HEDIS data using IDSS to NCQA? Will DHCFP require this in the future?

Yes, it is currently submitted via IDSS and we foresee no change in this process.

45. 2.1.3.2.A-8-Will DHCFP require or expect the MCOs and CMO to report their HEDIS performance measures to NCQA? If yes, are the MCOs and CMO required to publicly report their HEDIS results?

The current EQRO vendor reports the performance measures to NCQA. The DHCFP publicly reports the performance measures within our External Quality Review Annual Technical Report.

46. 2.1.3.2.A-8-Are all performance measures HEDIS or are other types of measures included as well?

MCO- Currently, all MCO performance measures are HEDIS, but the state has used non-HEDIS measures before, and may elect to use them in the future.
CMO- There are 22 performance measures that are validated by the EQRO vendor. They are non-HEDIS measures.
DBA- 1 HEDIS and 3 non-HEDIS measures are validated for this program.

47. 2.1.3.3-8-Confirm the CMO is not required to conduct PIPs (only the MCOs and PAHP will conduct PIPs). If the CMO is required to conduct PIPs, how many? And, clinical or non-clinical?

The CMO is not currently conducting PIPs.

48. 2.1.3.3-8-Can DHCP provide a list of PIP topics currently underway or expected to be implemented?

The SFY 2017 Technical Report can be located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

49. 2.1.3.6-9-Will the vendor develop the first annual technical report using the current EQRO's audit information/reports?

Yes. The information is owned by the DHCFP.

50. 2.1.3.6-9-What is the due date to submit the first annual technical report to DHCFP?

Technical Reports are due October 2018.

51. 2.1.3.6.H-10-Can you provide a copy of the latest QAPIS and Performance Tracking Tool?

Please refer to the DHCFP Managed Care Report link located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

52. 2.1.4-10-Confirm the Compliance Review standards are broken out and approximately 1/3 of the standards will be reviewed annually. So in a three year period, a comprehensive review is completed.

Refer to question 17 of this amendment.

53. 2.1.4-10-Are the Compliance Reviews to be conducted on-site or via desktop? 2.1.4-10-What programs are to be reviewed under the Compliance Reviews? MCO, DBA/PAHP, and CMO?

Compliance reviews are conducted for all MCOs and the DBA. MCO/DBA compliance reviews have both on-site and desktop components. The last CMO compliance review was conducted in FY 2015 and the report, which outlines the review standards can be located here: http://dhcfp.nv.gov/Pgms/BLU/HCGPOriginal/ Nevada DHCFP is proposing to phase out of the CMO program, and if phase out is completed, then the CMO contract will end June 30, 2018. Nevada may elect to implement a similar program in the future, which may require EQRO compliance efforts.

54. 2.1.5.1. C-11-Please define what DCHFP means by "omission studies"?

During an encounter data validation, an EQRO vendor will often speak to the encounter data completeness and accuracy. This would include information related to data omission rates for various services.

55. 2.1.5.2-11-Provide clarification regarding the differences between the CMO, the Care Coordination Vendor, and the CMO Vendor.

2.1.5.2A. and B. are both referencing the same vendor. Currently, DHCFP has a contract with our CMO vendor through June 2018. This contract may not be extended if the CMO program is phased out, however a similar vendor/service for care coordination may exist in the near future (2019).

56. 2.1.5.2-11-Are activities A and B mandatory activities for the Nevada Medicaid Care Coordination program?

Yes, they are part of the Special Terms and Conditions of the waiver.

57. 2.1.5.6-13-Should the vendor submit technical assistance costs as part of the cost proposal or will costs be submitted on a case-by-case basis when a request is received from DHCFP?

These can be submitted on a case-by-case basis with a SOW when request is received from the Division.

58. 2.2.9-14-"Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor's compliance."

This is not a question.

59. How does this statement apply to tasks under the EQRO scope of work? Can you provide a reference to the specific regulation this requirement refers to?

Refer to the beginning of this amendment. Section 2.2.9 has been removed.

60. Section 4- page 20-Can DHCFP revise the cost proposal template and shade or block the cells that do not require a cost (as not all tasks are being completed for each entity)? This will eliminate additional costs that are not necessary.

The Division has provided an updated cost proposal template. Cells for costs that are not necessary or that cannot be determined without an additional SOW have been removed.

61. Section 4- page 20-Clarify which tasks require a separate Title XIX (Medicaid) and XXI (CHIP) cost. For example, one Annual Technical Report will address Medicaid and CHIP. Would DHCFP like for the costs of one Annual Technical Report be broken down to the Medicaid and CHIP level?

Yes.

62. Section 4- page 20-Confirm a total (all three MCOs) Medicaid and CHIP cost should be provided for each activity and not a per MCO cost.

Costs should be broken out as outlined within the cost proposal template. The template does not allow for costs to be broken out by each separate MCO.

63. Section 4- page20-Please revise the RFP citations on the cost proposal template. The citations are not consistently matching up with the RFP. For example, references in the cost proposal template are based on three numbers X.X.X and references in the RFP are based on four numbers X.X.X.X.

Refer to beginning of this amendment for RFP submittal change.

64. Section 4- page 20-For Attachment G, detail is requested for the cost. Please give examples of what is expected.

Refer to the answer provided for question 60. Additional detail will not be provided at this time.

65. 1. PROJECT OVERVIEW-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings for pricing by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in previous RFPs?

See revised cost schedule at the beginning of this amendment.

67. 2. SCOPE OF WORK-2.1.2.1-7-Does the DHCFP anticipate conducting the encounter data validation study for the DBA in FY 2019 or FY 2020?

FY 2019

68. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please confirm the anticipated number of entities to be considered in the studies (i.e., MCOs, FFS, PAHP).

Possibly 3 MCOs, 1 DBA, 1 CMO, and FFS.

69. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Will the data necessary to complete focused study analyses be obtained from the managed care entities (i.e., MCOs, PAHP, etc.), from the DHCFP, or through a direct connection to the DHCFP's data systems?

Depending on the study the data may come directly from managed care organizations, the DBA, or from the Division.

70. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Has the DHCFP identified clinical or non-clinical focused study topics for the first contract year? Are there clinical or non-clinical areas of interest to the DHCFP for purposes of studies on quality?

Topics have not yet been identified for the contract period.

71. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please clarify the DHCFP's expectations regarding the frequency and timing of the focused studies (i.e., one study per year to be completed during the contract year).

The DHCFP has not determined the number of optional studies to be conducted during the contract period.

72. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

The study topic will likely determine the data sources. Previous studies have included administrative data, hybrid, and surveys.

a. If a hybrid methodology is requested, will the selected study sample be based on a statewide sample, or should the sample be stratified by FFS/MCOs such that inter-plan comparisons can be made?

It is likely that the sample would be stratified by FFS/MCO so that inter-plan comparisons can be made.

73. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.3-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs' provider contracts outline any requirements for the procurement and submission of medical records to the EQRO?

Reference RFP 3260 Section 3.10.18.1 Accessibility and Availability of Medical Records.

74. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11- As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs have a minimum required timeframe to procure and submit medical records for a focused study?

Timeframes for data submission specific to special projects are usually presented to the MCOs and adjusted if needed after discussion. A calendar of project deliverables and deadlines are provided to the plans for adherence.

75. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, will the FFS/MCOs be expected to procure and submit requested medical records to the EQRO for abstraction, or will the EQRO be required to abstract the medical records from either physician offices and/or the FFS/MCOs' offices?

The FFS/MCOs will be expected to procure and submit requested medical records to the EQRO.

76. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for creating a crosswalk of MCO provider specialty types for all three MCOs and the FFS program to ensure consistency in categorizing providers?

Yes.

77. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for working with the DHCFP to create network adequacy standards for specialty providers if such standards are not currently defined?

The DHCFP plans on adopting network adequacy standards as established by the Division of Insurance; however, for specialty providers that the DOI have not assigned network

adequacy standards for the DHCFP will require the EQRO to assist in identifying/establishing standards for the remaining provider specialties identified within 42 CFR 438.68(b).

78. 2. SCOPE OF WORK-2.1.3.4-9-Is the DHCFP interested in validation results reported for a specific list of provider specialties or provider groups? How many provider specialties does the DHCFP anticipate including in the analysis for each managed care entity (i.e., MCOs, and DBA/PAHP)?

Refer to the last DHCFP network adequacy report located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/
Future reporting requirements may not exactly mirror previous reports. The Division consults with the Department of Health and Human Services prior to proceeding with Network Adequacy studies to incorporate their recommendations.

79. 4. COST-4-20-The RFP states, "Vendors must provide detailed fixed prices for all costs associated with the responsibilities and related services. Clearly specify the nature of all expenses anticipated."

a. In addition to completing Attachment G, Cost Schedule, does the DHCFP require detail on all direct costs associated with the tasks, as well as a budget narrative?

The DHCFP does not require additional cost information outside of the documentation required within Attachment G.

80. 2. SCOPE OF WORK-2.1.5-10 - 11-The RFP states, “The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c)....” Please confirm this citation should be 42 CFR 438.358(c), as stated later in the text.

The correct citation is 42 CFR 438.358 (C). Refer to the beginning of this document.

81. 2. SCOPE OF WORK-2.1.5-10, 11-The last sentence in the cited paragraph states, "Optional activities…may include." The list that follows, 2.1.5.2.a and b, includes compliance audit and performance measure validation for the CMO vendor, which are also listed in the requirement at 2.1.1 for the vendor to perform mandatory activities for the CMO, inclusive of a compliance review (2.1.1.3) and performance measure validation (2.1.1.2).

a. For purposes of completing the cost schedule, please clarify whether these are optional or mandatory activities the vendor must perform.

These are optional activities.

83. 2. SCOPE OF WORK-2.1.5.2 B-11-Will the vendor be required to provide a validation of source data (claims processing vendor) as part of the validation of performance measures for the DHCFP's CMO vendor?

Yes.

84. 2. SCOPE OF WORK-2.1.5.3-11-Does the DHCFP anticipate the vendor will be required to produce two Quality Rating Systems—one for Nevada Check Up and one for Medicaid?

Yes, one quality rating system inclusive of both Nevada Check Up and Medicaid beneficiaries.

85. 2. SCOPE OF WORK-2.1.5.4 C-12-Other than conducting performance measure calculation and/or validation, can the DHCFP clarify the activities associated with the evaluation of the implementation of performance measures for the ABD population?

The EQRO would calculate and validate the ABD performance measures.

86. 2. SCOPE OF WORK-2.1.5.4.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new ABD MCO vendor. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

87. 2. SCOPE OF WORK-2.1.5.5.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new MCO vendor for rural county expansion. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

88. 2. SCOPE OF WORK-2.1.5.4.A, B, C-12 & 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

Attachment G has been revised. Optional activities will be priced by project when a request and SOW is provided to the vendor. Refer to the beginning of this document.

89. 2. SCOPE OF WORK-2.2.5-13-The Code of Federal Regulations citation listed as the reference for the EQRO independence requirements (i.e., §438.310(c)(2) appears to be incorrect. Please confirm the DHCFP intended to refer instead to §438.354(c)(2).

§438.354(c)(2)is the correct citation. Refer to the beginning of this amendment.

90. 2. SCOPE OF WORK-2.2.9-14-Subsection 2.2.9 states, "Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance, as defined by CMS regulation and policy."

    a. Compliance with ICD and EDI are more applicable to the original data submitters, as opposed to secondary data users. Please clarify what constitutes compliance with ICD and EDI for secondary data users.

    Refer to the beginning of this amendment. Section 2.2.9 has been removed.

91. 2. SCOPE OF WORK-2.4.3 -15-The RFP states, "Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service state date, all deliverables to permit any DHCFP identified modifications." Will the DHCFP please specify the deliverables it expects to receive within 10 working days of the service start date? Are these

separate from the work plan, noted in Section 2.4.1 of the RFP, which is due no later than one month following notification that the vendor has been awarded the contract?

The work plan is to be delivered within one month from the notification of contract award. Within 10 days of the service start date the vendor will supply a list of all deliverables they are requesting modifications be made for. The DHCFP will have 20 working days from receipt to respond to the requested modifications/revisions. If the DHCFP does not respond by the 20th working day after receipt, then the DHCFP's approval of the submission will be assumed as granted.

92. 2. SCOPE OF WORK-2.1.1.2-7-Will the DBA performance measures be standardized measures or measures developed by the DHCFP?

DBA- 1 HEDIS and 3 non-HEDIS measures

93. 2. SCOPE OF WORK-2.1.1.2-7-If the DHCFP-developed performance measures are used, will the DHCFP update and maintain the methodologies, or will the vendor update and maintain the methodologies?

The vendor will update and maintain the methodologies.

94. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor be responsible for updating and maintaining the performance measure specifications for the CMO?

Yes.

95. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor provide technical assistance in determining or selecting performance measures for the CMO program?

The current vendor provided technical assistance with selecting performance measures for the CMO. CMO performance measures were identified at the beginning of the demonstration waiver. The demonstration waiver will expire 6/30/2018.

96. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to administer a survey?

Yes.

97. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm only one (1) reporting unit (i.e., the entire Nevada Medicaid FFS population) will be sampled.

This is true of the current project. Future projects may differ in scope. The DHCFP would provide a request outlining the SOW of future projects and request a cost proposal at that time.

98. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will both adult and children be surveyed?

The population and type of CAHPS survey(s) would be determined prior to implementing the optional activity. The vendor would be provided a SOW and a cost proposal would be requested by DHCFP prior to initiating the project.

99. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. If children are surveyed, which version of the CAHPS survey instrument will be required for administration:

    (1) the Child Medicaid CAHPS Survey without the Children with Chronic Condition measurement set or;

    (2) the Child Medicaid CAHPS Survey with the Children with Chronic Conditions measurement set?

    See question 98 of this amendment.

100. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. How many supplemental items will be added to the standard CAHPS surveys?

    The DHCFP would determine project details once it is decided to move forward with the optional activity.

101. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm whether the DHCFP requires oversampling.

    In the event DHCFP selects this optional activity the Division would require oversampling.

102. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. In which languages will the surveys be administered?

    In the event DHCFP selects this optional activity the surveys would likely be administered in English and Spanish.

103. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm a standard mixed-mode methodology will be employed for all survey administration activities (i.e., two mailings, two reminder postcards, and telephone follow-up).

    The DHCFP would determine project details once it is decided to move forward with the optional activity.

104. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will survey results be submitted to the NCQA and/or AHRQ's CAHPS Health Plan Survey database?

    Yes.

105. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. What deliverables will be required for this activity?

The DHCFP would determine project details once it is decided to move forward with the optional activity.

106. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to validate?

In the event DHCFP selects this optional activity the vendor would be required to validate.

107. 2. SCOPE OF WORK-2.1.2.3-8-Regarding the calculation performance measures, in addition to those reported by health plans, does the DHCFP anticipate having the vendor calculate hybrid measures?

Measures for this optional activity have not yet been selected. It is possible that hybrid measures may be selected.

108. 2. SCOPE OF WORK-2.1.2.3-8-Please confirm the vendor will validate both clinical and non-clinical PIPs, for a total of five (5) PIPs per MCO to be validated.

RFP 3491 Section 2.1.3.3 states that mandatory activities would include the validation of 2 clinical PIPs and 3 non-clinical PIPs (5 PIPs) per MCO; and one clinical PIP and one non-clinical PIP for the DBA.

109. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the approximate number of measures the vendor will be required to calculate for the FFS population.

Currently, there are 9 administrative measures that are calculated for the FFS population.

110. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the number of sub-populations within the FFS population the vendor will be required to calculate measures.

The FFS performance measures are: Follow up after hospitalization after hospitalization for Mental Illness (FUH), Mental Health Utilization (MPT), Follow up after ED visit foe Mental Illness, Follow up after ED visit for ETOH and other Drugs, Use of opioids at high dosage (UOD), Use of opioids from multiple providers (UOP), Children and Adolescents access to primary care (CAP), Annual Dental Visit (ADV), and Adult Access to primary care (AAP).

111. 2. SCOPE OF WORK-2.1.2.6-8-Please clarify the type of assistance that will be required for the Quality Rating System for the FFS population. Will this assistance be limited to technical assistance or development and production of a Quality Rating System?

Development and production of the QRS.

112. 2. SCOPE OF WORK-2.1.3.2 C & D-8-Please confirm if the DHCFP anticipates including both Medicaid and CHIP HEDIS rates in the comparative analysis? If yes, does the DHCFP anticipate receiving separate reports for each population or a single report only?

The expectation is the Medicaid and CHIP rates will be included in a comparative analysis within in a single report. Please refer to our previous Technical Reports for more information.
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

113. 2. SCOPE OF WORK-2.1.3.2 A-8-The RFP states that validation will be required for HEDIS and other performance measures. Will the DHCFP provide a list of the non-HEDIS measures that are required for reporting by the MCO, DBA/PAHP, and CMO? Are any of the non-HEDIS measures required to use hybrid methodology?

Currently there are 26 HEDIS measures for the MCOs, 1 HEDIS and 3 non-HEDIS measures for the DBA, and 22 HEDIS like measures for the CMO. The non-HEDIS measures for the DBA have not yet been determined, and it is uncertain the number that may use a hybrid methodology at this time.

114. 3. COMPANY BACKGROUND AND REFERENCES-3.4-20 & 40-Section 3.4 states that a resume is required "for each key personnel…;" however, Attachment F indicates a resume is to be completed "for all proposed prime contractor staff and proposed subcontractor staff." Due to a significant difference in the number of resumes potentially required, please confirm whether the DHCFP requires submission of all proposed vendor and subcontractor staff resumes or only resumes for those designated as key vendor and contractor personnel.

Submit forms for all proposed contractor and subcontractor staff.

115. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.1-27-The scoring for cost indicates that the total cost for the proposal will be included in the cost formula to determine the cost criteria score. There are several tasks listed in Section 2.1.5 Technical Assistance and Optional Activities, that may or may not be requested by the DHCFP, which are included in the cost schedule in Attachment G. Further, Section 2.1.5.6 does not specify the tasks related to technical assistance or consulting, but the activity seems to be referenced in the cost schedule in Attachment G. Would the DHCFP consider removing costs associated with undefined technical assistance and consulting from the cost formula to determine the cost criteria score?

No, cost must be evaluated per NRS 333. However, the cost has been revised. Refer to beginning of this amendment.

116. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.6-28-This requirements states, "Each vendor shall include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the vendor or in which the vendor has been judged guilty or liable." Please provide the proposal part and section in which the State would like the response, even if there is nothing to report.

Refer to Section 3.1.7 of RFP 3491.

117. ATTACHMENT E – REFERENCE QUESTIONNAIRE-Attachment E-39-There is an inconsistency between the Instructions to Proposing Vendor and the Reference Questionnaire regarding where the Reference should be returned. The Instructions to Proposing Vendor states it should be returned to: rlmiller@admin.nv.gov. However, the Reference Questionnaire states:

Business reference is requested to submit the completed Reference Questionnaire via email or facsimile to:

State of Nevada, Purchasing Division
Subject: RFP 3491

Attention: Purchasing Division
Email: rfpdocs@admin.nv.gov
Fax: 775-684-0188

Please confirm the correct e-mail address for the return of the Reference Questionnaire.

The correct e-mail is rlmiller@admin.nv.gov

118. ATTACHMENT F– PROPOSED STAFF RESUME-Attachment F-40-Please clarify what is expected in the field entitled, "# of Years in Classification". Is this the number of years the staff member has been in their current position?

This is the number of years doing this type of service.

119. ATTACHMENT G – COST SCHEDULE-Attachment G-41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

Refer to beginning of this amendment for RFP submittal change.

120. ATTACHMENT G – COST SCHEDULE-Attachment G-41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

The Cost Schedule has been revised. Please review revised Attachment G at the beginning of this amendment.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Health Services Advisory Group, Inc.

Authorized Signature: Mary Ellen Dalton

Title: President and Chief Executive Officer Date: 2-15-18

This document must be submitted in the "State Documents" section of vendors' technical proposal.

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 2to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 8, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

Clarification from Amendment 1:

Old Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

New Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    The MCO's are required to be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor.

QUESTIONS & ANSWERS:

1. Since the State re-issued a new version of Attachment G Cost Proposal form, will the State please answer the following clarification questions:

    a. New Attachment G - Cost Proposal Form: Is the State expecting a price for each cell in this new Attachment (whether or not the Activity may be applicable to the listed column/program/entity)?

No. Cells that are not applicable shall be marked N/A.

b. New Attachment G - Cost Proposal Form: If PIPs are not currently conducted by the CMO-FFS entity, is the Vendor allowed to list a $0 price in the validation of performance improvement project cost cells? If not allowed, in what year does the State expect this Activity to be applicable to the CMO-FFS entity/program?

The state has no expectation of PIP activities for the current CMO-FFS vendor, and the state does not have a projected date of activity for future CMO-FFS vendors/projects. Please indicate N/A in cells that a cost is not applicable.

c. New Attachment G - Cost Proposal Form: If an Activity can be conducted under one entity/program, but cover multiple entities/programs, does the State want one price in the appropriate column (e.g., MCO Title XIX) and other columns/entities/programs listed with $0 (e.g., MCO Title XXI) or does the State want costs to be allocated across all columns/entities/programs?

The state expects a cost per activity by population (MCO Title XIX, MCO Title XXI, CMO FFS, etc). If the population is not applicable to the activity, then N/A can be indicated within the cell. The state would interpret $0 as an indication the activity would be completed for no charge.

2. Can the State please reconcile responses to Questions 36 and 38 regarding whether suggested modifications/exceptions to the contract are permitted or not?

No.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Health Services Advisory Group, Inc.

Authorized Signature: Mary Ellen Dalton

Title: President and Chief Executive Officer Date: 2-15-18

This document must be submitted in the "State Documents" section of vendors' technical proposal.

B. Attachment A – Confidentiality and Certification of Indemnification signed by an individual authorized to bind the organization.

B ATTACHMENT A

The signed Attachment A – Confidentiality and Certification of Indemnification can be found on the following page.

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **shall not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the submittal instructions of this RFP, vendors are requested to submit confidential information in separate files marked "**Part IB Confidential Technical**" and "**Part III Confidential Financial**".

The State shall not be responsible for any information contained within the proposal. If vendors do not comply with the labeling and packing requirements, proposals shall be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that shall be in an open meeting format, the proposals shall remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act shall constitute a complete waiver and all submitted information shall become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information.

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information			
YES		NO	MED
Justification for Confidential Status			

Part III – Confidential Financial Information			
YES		NO	MED
Justification for Confidential Status			

Company Name
Health Services Advisory Group, Inc. (HSAG)

Signature
Mary Ellen Dalton

Print Name
Mary Ellen Dalton, PhD, MBA, RN

2-15-18
Date

This document shall be submitted in Section IV of vendor's technical proposal

C. Attachment B – Vendor Certifications signed by an individual authorized to bind the organization.

C ATTACHMENT B

The signed Vendor Certifications form can be found on the following page.

ATTACHMENT B – VENDOR CERTIFICATIONS

Vendor agrees and shall comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and shall not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, shall remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, shall remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals shall be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion shall be in writing and included in the proposal at the time of submission.

(7) Each vendor shall disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict shall be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest shall automatically result in the disqualification of a vendor's proposal. An award shall not be made where a conflict of interest exists. The State shall determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and shall be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor shall certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal shall be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

Vendor Company Name
Health Services Advisory Group, Inc. (HSAG)

Vendor Signature

Mary Ellen Dalton

Print Name Mary Ellen Dalton, PhD, MBA, RN
President and Chief Executive Officer

2-15-18
Date

This document shall be submitted in Section IV of vendor's technical proposal

D. Attachment H – Certification Regarding Lobbying signed by an individual authorized to bind the organization.

D ATTACHMENT H

The signed Attachment H – Certification Regarding Lobbying can be found on the following page.

ATTACHMENT H – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or shall be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By: Mary Ellen Dalton 2-15-18

Signature of Official Authorized to Sign Application — Date

For: Health Services Advisory Group, Inc. (HSAG)

Vendor Name

Request for Proposal: 3491, External Quality Review Organization (EQRO)

Project Title

This document shall be submitted in Section IV of vendor's technical proposal

E. Copies of any vendor licensing agreements and/or hardware and software maintenance agreements.

E LICENSING AGREEMENTS AND/OR HARDWARE AND SOFTWARE MAINTENANCE AGREEMENTS

Because HSAG is not providing a software solution for this contract, this requirement is not applicable.

F. Copies of applicable certifications and/or licenses.

F APPLICABLE CERTIFICATIONS AND/OR LICENSES

Copies of HSAG's certifications and licenses can be found beginning on the following page.

HSAG is certified as an NCQA Licensed Organization (LO), one of only nine firms, to conduct Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits.

National Committee for Quality Assurance

is pleased to announce

Health Services Advisory Group, Inc.

fulfilled all the necessary requirements
to conduct NCQA HEDIS® Compliance Audits™
and attained the designation of

NCQA-LICENSED ORGANIZATION

NCQA
Measuring quality.
Improving health care.

MARGARET E. O' KANE
PRESIDENT

DATE LICENSED: 11/1/2017 **EXPIRATION DATE:** 10/31/18

HSAG is an NCQA-Certified HEDIS Survey Vendor (CAHPS®[1]) and has met all requirements for the HEDIS Vendor Certification Program since 1999.

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

CERTIFIED NCQA HEDIS® SURVEY VENDOR 2018

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2017
DATE GRANTED

October 31, 2018
EXPIRATION DATE

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

Section V – Scope of Work

2.1

The services to be provided under the resulting contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for MCOs, DBA/PAHP, and the CMO. The contract will allow the DHCFP to be compliant with federal EQR regulations and rules. The specifications for deliverables required under this RFP may evolve from year to year in response to program changes.

2.1.1 The selected vendor will be required under the contract to perform tasks and functions identified in the contract and to perform them according to specified levels of quality and comprehensiveness as determined by DHCFP. These mandatory activities are as follows:

- 2.1.1.1 Performance Improvement Project Validation;
- 2.1.1.2 Performance Measurement Validation;
- 2.1.1.3 A review, conducted within the previous 3-year period, to determine plans 'compliance with the standards set forth in subpart D of 42 CFR 438 relating to access; care coordination; amount, duration, and scope of covered services and other plan standards; and
- 2.1.1.4 Network Adequacy Validation.

Health Services Advisory Group, Inc. (HSAG) understands and will comply with the requirements set forth in 2.1.1 through 2.1.1.4. Furthermore, HSAG understands that if the Nevada Medicaid and Check Up programs change during the External Quality Review Organization (EQRO) contract period, HSAG may be required to comply with changes to the specifications for contract deliverables.

MANDATORY EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Performance Improvement Project Validation

HSAG understands the validation of performance improvement projects (PIPs) is a mandatory activity outlined in 42 CFR §438.358(b)(1)(i) and the Nevada EQRO contract. HSAG is fully prepared to validate PIPs conducted by the Division of Health Care Financing and Policy's (DHCFP's) contracted managed care organizations (MCOs) and dental benefit administrator/prepaid ambulatory health plan (DBA/PAHP). HSAG adheres to the Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.

The HSAG PIP team comprises registered nurses, licensed social workers, a healthcare measures specialist, a healthcare analyst, and a biostatistician. Both the registered nurses and social workers are Certified Professional in Healthcare Quality (CPHQ) and six sigma black belt-certified. The healthcare analyst and biostatistician bring a wealth of expertise to the validation process, including experience in study design and methodology, sampling, epidemiology, and statistical testing. The entire team are subject matter experts in quality improvement science and the use of rapid-cycle techniques to drive improvement. HSAG currently validates over 400 PIPs annually in 14 states: Nevada, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Utah, Vermont, and Virginia.

As Nevada's current EQRO, HSAG has validated PIPs for the Medicaid and Check Up program since 2004 and provides technical assistance and training through webinars, conference calls, and on-site meetings.

HSAG has developed a specific form for Nevada's health plans to complete its PIP project updates, along with accompanying instructions, to aid in documenting each step of its PIP process and addressing all CMS protocol requirements for conducting PIPs. The goal of HSAG's PIP validation in Nevada is to ensure the DHCFP and key stakeholders are confident that any reported improvement in outcomes is related to a given PIP.

"The PIP summary form and validation tool developed by HSAG were outstanding." — CMS

HSAG facilitates numerous quality improvement projects to improve quality, accessibility, and timeliness of care for individuals enrolled in Medicaid or Children's Health Insurance Program (CHIP) programs. HSAG's PIP team members are subject matter experts, with extensive experience implementing quality improvement techniques. For example, the PIP team supports the facilitation of quality and performance improvement projects in its EQRO-contract states and provides training and education to the health plans/state Medicaid agencies on the following:

- ***Performing drill-down analysis of health plan data to identify opportunities for improvement***
- ***Process mapping***
- ***Conducting failure modes and effects analysis***
- ***Small-scale intervention testing using Plan-Do-Study-Act cycles***
- ***Developing methods for making fundamental change, such as benchmarking and learning from others; using technology; thinking critically, logically, and creatively about the current system; and using change concepts***
- ***Overcoming quality improvement obstacles***
- ***Developing improvement measures/metrics***
- ***Developing study designs/methodologies***

HSAG assists states and their health plans with performance improvement activities and projects for a variety of topics, such as:

- ***Reducing avoidable emergency department visits.***
- ***Improving coordination and communication of care between physical health and behavioral health plans.***
- ***Improving care for members with diabetes.***
- ***Ensuring timely initiation of long term services and supports (LTSS).***
- ***EPSDT services and improving childhood immunization rates.***

Detailed information regarding HSAG's methodology and approach to PIP validation is provided in our response to Sections 2.1.2.4 and 2.1.3.3, respectively.

Performance Measurement Validation (PMV)

As the EQRO for the State of Nevada, HSAG will conduct the and performance measurement validation for the MCOs, DBA/PAHP, and the care management organization (CMO) or another vendor if selected, in accordance with 42 CFR §438.358(b)(1)(ii) and §438.358(b)(2) and the Nevada EQRO contract, using Healthcare Effectiveness Data and Information Set (HEDIS®[2]) specifications. HSAG currently adheres to the DHHS, CMS publication, EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012, when performing PMV activities.

[2] ***HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)***

With 18 years of experience performing performance measure validation audits, HSAG uses the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ process or applicable CMS protocol to validate performance measures. HSAG's experience encompasses validating a wide spectrum of measures, such as HEDIS, CMS' Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), CMS' Core Set of Children's Health Care Quality Measures for Medicaid (Child Core Set), state-specific performance measures, and modified HEDIS measures. HSAG's audit program has matured and become more efficient over time due to its experience performing more than 750 HEDIS audits and more than 650 performance measure validation audits. HSAG's customers benefit from efficiencies gained and best practices learned over time.

As a NCQA-licensed HEDIS Compliance Audit Organization, HSAG has conducted HEDIS compliance audits since 1998. HSAG employs five certified HEDIS compliance auditors (CHCAs) and has established working relationships with other CHCA consultants to ensure all customer validation needs are met in a timely manner. It performs performance measure validation activities in 16 states: Nevada, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia. HSAG has developed expertise in applying the validation process to a variety of MCOs, including Medicare-Medicaid plans, pre-paid inpatient health plans (PIHPs), PAHPs, substance use disorder service organizations, organizations providing services to special needs and long-term services and supports populations, and other healthcare delivery systems.

Performance measure validation helps to ensure health plans have sufficient systems and processes necessary to provide accurate and complete information for calculating valid performance measure rates according to specifications required by a state. HSAG will tailor its approach to performance measure validation to ensure optimal support of the DHCFP's overall goals and objectives.

Details regarding HSAG's methodology and approach to PMV validation are provided in our response to Sections 2.1.3.1 and 2.1.3.2, respectively.

Review of Plans' Compliance with Standards

For more than 30 years, HSAG has actively engaged in evaluating the quality of care for Medicaid recipients, and has provided EQR-related services, including compliance reviews. HSAG will perform compliance reviews in accordance with 42 CFR §438.358(b)(1)(iii) and §438.358(b)(2) and for the Nevada EQRO contract.

In addition to conducting compliance reviews for Nevada, HSAG conducts compliance reviews in the following states: Colorado, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia. Because each state Medicaid program is unique, HSAG tailors its approach to EQR activities to complement each state's Medicaid program. The depth and breadth of HSAG's compliance review team has developed from years of experience conducting compliance reviews for Medicaid managed care programs that include MCOs, PIHPs, prepaid ambulatory health plans (PAHPs), primary care case management programs (PCCMs), accountable care organizations (ACOs), primary care medical homes (PCMHs), and other care management vendors.

HSAG collaborates with each state to customize its compliance review tools to address a state's regulatory differences, as well as state-specific contract requirements for each health plan type. Our review tools, tracking forms, interview guides, site visit agendas, on-site interview questions, pre-assessment information lists, and other supporting working papers are consistent with the DHHS, CMS publication, EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for EQR, Version 2.0, September 2012.

HSAG brings a deep and mature understanding of the federal Medicaid managed care regulations and their applicability to Medicaid MCOs, DBA/PAHPs, and PCCMs, which is how CMS categorizes the Nevada CMO. Because HSAG has served as the DHCFP's EQRO since 2000, HSAG is uniquely familiar with the history and nuances of Nevada's MCO, the DBA/PAHP, and the CMO programs. This knowledge exclusively positions HSAG to assist the DHCFP and its managed care vendors with ensuring compliance with standards established by the DHCFP and mandatory CMS requirements.

Through HSAG's partnership with the DHCFP over the past 17 years, HSAG has conducted compliance reviews for the DHCFP's MCOs, as well as targeted case management reviews, to ensure MCOs provide care management services consistent with the requirements of the DHCFP contract. Additionally, HSAG performed the readiness review and a compliance review of the CMO. Most recently, HSAG performed the operational and information systems (IS) readiness reviews of two new MCOs awarded contracts in response to RFP 3260. HSAG also performed the operational and IS readiness review of the DBA/PAHP which was awarded a contract in response to RFP 3425. This extensive experience performing operational and IS readiness reviews for new MCOs, the DBA/PAHP, and the CMO demonstrates HSAG's in-depth understanding of the provisions of each contract and its ability to assess each managed care vendor's compliance with state and federal standards.

HSAG's compliance review team members who conduct compliance reviews for Nevada hold advanced degrees in health-related fields and multi-state experience performing compliance and readiness reviews for MCOs, PIHPs, dental plans, and CMOs.

HSAG's knowledge of and experience in Nevada uniquely positions it to continue to assist the DHCFP and its contracted health plans in ensuring compliance with federal managed care regulations and established contract requirements.

HSAG reviewers are prepared to provide the DHCFP and its MCOs, the DBA/PAHP, and the CMO with technical guidance during the compliance review activities to incorporate the requirements articulated in the final CMS Medicaid managed care regulations released on May 6, 2016. Many became effective in July of 2017. These new final rules represent a significant revision to Medicaid managed care and impact the way states and health plans operate their programs. As the new final rules become effective over the next two years, and with new or revised CMS EQR protocols anticipated, HSAG stands ready to assist the DHCFP to ensure compliance with these major revisions to Medicaid managed care.

Detailed information regarding HSAG's methodology and approach to conducting compliance reviews is provided in our response to Sections 2.1.4. and 2.1.5.2 (A), respectively.

Network Adequacy Validation

For the past 15 years, HSAG has planned, organized, and completed 44 managed care provider network adequacy assessments in eight states: Nevada, California, Florida, Illinois, Iowa, New Hampshire, Ohio, and Tennessee. The HSAG staff performing the network adequacy validation activities for the DHCFP comprises an analytics director, analytics associate director, and analysts, all of whom perform these activities for HSAG customers. While specific review topics vary by state and year, the staff fulfill the purpose of the reviews—ensuring each MCO, PIHP, and PAHP has adequate provider networks necessary to deliver healthcare services to their members in their coverage areas.

As the EQRO for the State of Nevada, HSAG will validate network adequacy annually for all MCOs and the DBA/PAHP in accordance with 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5) and the Nevada EQRO contract. HSAG is aware that CMS expects to publish the validation of network

adequacy protocols in 2018. Upon issuance, HSAG will collaborate with the DHCFP to establish a timeline and process for implementation of the new protocols.

A detailed discussion of HSAG's methodology and approach to network adequacy validation is provided in our response to Section 2.1.3.4.

2.1.2	During the length of the contract, work requests may be made of the Vendor at the sole discretion of the DHCFP for optional activities described in 42 CFR 438.358(c) or comparable activities that assess the quality of care or provide for the control of utilization of the DHCFP fee-for-service program. Optional activities may include: 2.1.2.1 Validation of encounter data; 2.1.2.2 Administration or validation of consumer or provider surveys of quality of care; 2.1.2.3 Calculation of performance measures in addition to those reported by health plans; 2.1.2.4 Conduct of PIPs in addition to those conducted by health plans; 2.1.2.5 Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time; and 2.1.2.6 Assistance with the Quality Rating System.

HSAG understands and will comply with the requirements set forth in 2.1.2.1 through 2.1.2.6.

OPTIONAL EQR ACTIVITIES

Validation of Encounter Data

As the EQRO for the State of Nevada, HSAG understands that it may be required to validate encounter data annually for managed care vendors, including MCOs and the DBA/PAHP, in accordance with 42 CFR §438.602(e) and 42 CFR §438.358(c)(1). HSAG is currently conducting an encounter data validation (EDV) study for the DHCFP. Because this study is evaluating the encounter data completeness and accuracy of encounters generated prior to July 1, 2017, the HSAG study includes evaluating the encounters for Amerigroup and Health Plan of Nevada (HPN). In future studies that include all three MCOs and the DBA/PAHP, HSAG is prepared to complete the EDV study and will provide each managed care vendor with individual plan reports on EDV detailing the results of validations, including findings, recommendations for improvement, requirements for corrective actions, and review of any outstanding required correction action(s). Because the process of conducting EDV studies is the same, regardless of the managed care vendor type involved in the study, HSAG's description to complete EDV refers to MCOs and the DBA/PAHP collectively as "vendors."

HSAG's experience in conducting encounter data evaluations spans more than 15 years and includes extensive work in both physical health, behavioral health, and dental Medicaid managed care. To date, HSAG has completed or is currently conducting 60 EDV studies across 13 states. HSAG understands that validation of encounter data is critical to ensuring that data submitted are complete and accurate reflections of the care provided to Medicaid members—a necessary requirement so that reports, quality measures, and capitation payment rates developed from the data are reliable and comparable across all health plans. As the EQRO, HSAG will conduct a study consistent with CMS EQR Protocol 4, Validation of Encounter Data Reported by the MCO: a Voluntary Protocol for External Quality Review (EQR), Version 2.0. September 2012, to evaluate the accuracy and completeness of the encounter data the contracted vendors submit to the DHCFP. The protocol consists of five activities:

- ***Review of the State's requirements for collecting and submitting encounter data***
- ***Review of the MCO's capacity to produce accurate and complete encounter data***
- ***Analysis of the MCO's electronic encounter data for accuracy and completeness***

- ***Review of medical records to confirm findings of analysis of encounter data***
- ***Submission of findings***

HSAG has developed a core competency in evaluating encounter data integrity through information systems (IS) review, administrative profiles, comparative analyses of vendor and state Medicaid encounter data, and medical/clinical record review (MRR). HSAG's approach effectively identifies and confirms the quality of encounter data that Nevada's managed care program collects and maintains. Detailed information regarding HSAG's methodology and approach to encounter data validation is provided in our response to Section 2.1.5.1.C.

Administration or Validation of Consumer or Provider Quality of Care Surveys

As an industry leader in measuring the effectiveness of healthcare, HSAG has extensive experience in survey management, instrument design, and report development. In 1995, HSAG began to develop health outcomes expertise with surveys that included patient-reported health status, quality of life, and satisfaction. HSAG quickly became a leader in the field by designing and conducting scientifically sound quality-of-life and outcomes studies and by collecting, analyzing, and reporting data for federal and state agencies, managed care plans, hospitals and academic medical centers, and private sector healthcare companies. HSAG has extensive experience performing Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] analyses for several state Medicaid agencies and CMS. In addition, HSAG:

- ***Was the first EQRO to become a NCQA-certified HEDIS CAHPS survey vendor and continues in that capacity since the program's inception in 1999.***
- ***Possesses a wealth of knowledge performing CAHPS and related survey work for 14 state Medicaid agencies, including those states where HSAG ensures the quality, access, timeliness, and appropriateness of care for more than 45 percent of the nation's Medicaid recipients.***
- ***Has administered more than two million surveys to adult and child Medicaid members in an array of programs (including disabled, Temporary Assistance for Needy Families [TANF], and CHIP members), as well as surveys to evaluate special needs populations, such as the CAHPS Children with Chronic Conditions (CCC) module, Experience of Care and Health Outcomes (ECHO®) Survey, and the Home- and Community-based Services (HCBS) CAHPS Survey.***
- ***Possesses expertise in analyzing CAHPS and other survey-related data for state Medicaid agencies and Medicaid managed care plans, including plans serving special-needs populations.***
- ***Develops novel survey tools, including provider, care management, and quality of life surveys.***
- ***Performs validation of surveys in accordance with CMS' EQR Protocol 5: Validation and Implementation of Surveys: a Voluntary Protocol for External Quality Review (EQR), Version 2.0, September 2012.***

HSAG has carefully selected a highly qualified, experienced subcontractor, DataStat, Inc., to perform the survey administration. HSAG partners with DataStat on other contracts and is confident in its ability to perform on time and produce high-quality contract deliverables. DataStat is located in Ann Arbor, Michigan and has worked with HSAG for more than 20 years in providing data collection services for CAHPS, as well as for other surveys. DataStat is a proven partner in most of HSAG's survey work with multiple state Medicaid EQRO contracts and federal CMS contracts, including Nevada.

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

DataStat is an NCQA-certified HEDIS CAHPS vendor and has the capacity to handle large-scale mailing and computer assisted telephone interviewing (CATI) survey administrations.

HSAG recognizes the importance of employing a well-qualified and experienced staff. HSAG has assembled a strong survey team with over 25 years of combined survey/CAHPS experience, including a project director, analysts, and project manager. These staff members currently support the CAHPS survey administration, analysis, and reporting for the Nevada EQRO contract.

Calculation of Performance Measures

Performance Measures

HSAG will calculate performance measures in accordance with the DHCFP-approved technical specifications and CMS EQR Protocol 6: Calculation of Performance Measures: a Voluntary Protocol for External Quality Review (ERQ), Version 2.0, September 2012. HSAG has a wealth of experience calculating performance measures for eight states (Arizona, Arkansas, Colorado, Iowa, Nevada, New Hampshire, Ohio, Virginia). HSAG has extensive experience calculating a variety of performance measures across multiple health plans and populations, including HEDIS, HEDIS-like, CMS Core Measures, National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), and custom measures for several state Medicaid agencies. Further, as Nevada's EQRO, HSAG is calculating nine performance measures for the fee-for-service (FFS) population following HEDIS Technical Specifications for Health Plans, Volume 2.

In addition, HSAG has the unique experience of developing and calculating measures for national use that conform to the goals of the national quality strategy. HSAG previously held the contract to assist CMS with managing numerous measures across all healthcare settings. HSAG provided CMS with a set of management processes and decision criteria to guide the development, implementation, and maintenance of quality measures. HSAG will capitalize on this experience to review and provide feedback on State-selected performance measures. Please refer to HSAG's response to Section 2.1.2.3 for detailed information regarding HSAG's methodology and approach to the calculation of performance measures.

HSAG employs a streamlined process and approach for calculating a variety of performance measures for multiple state Medicaid agencies. HSAG developed and implemented the Performance Measurement Platform (PMP) used to calculate HEDIS, HEDIS-like, and other performance measures using administrative, registry, vital statistics, and medical record review data. HSAG has used PMP to calculate performance measures on behalf of several state Medicaid agencies. HSAG will develop a performance measurement worksheet that includes performance measure specifications for each measure, identify comparative benchmarking sources (e.g., national benchmarks, statewide performance standards), and outline any other information required to complete the performance measure calculation activity.

Collect Data and Verify Data Integrity

To prepare for data collection, HSAG will create a data request document and will convene a meeting to review the data request document with the DHCFP and any other delegated entities. This data request document will outline the data required for performance measure calculations (e.g., claims/encounter dates of service, provider file, etc.) and describe how HSAG will ensure the DHCFP and any other data providers transmits data to HSAG with appropriate privacy and security safeguards.

As part of the performance measure calculations, HSAG will collect data via a secure transfer mechanism and ensure that all data elements required for performance measure calculation, as defined in the performance measurement worksheet, are present. Next, HSAG will check the data for such items as valid procedure codes, valid diagnosis codes, correct field size and type, and valid date ranges. HSAG also will perform a series of data integrity checks to ensure that it can appropriately link different files and that discrepancies do not exist (e.g., ensure members in the claims are present within the enrollment files). HSAG will promptly communicate any issues identified with the data sources to the DHCFP and identify appropriate next steps, such as requesting data resubmission. Once HSAG deems all data are usable, it will integrate the data into its performance measure repository.

Calculate Performance Measures

Upon receipt of clean and accurate data, HSAG will proceed with calculating performance measures. To achieve the most appropriate and cost-effective analysis of performance measure data, HSAG will use SAS® software to perform all analytic activities.[4] HSAG will develop SAS programming code for each performance measure, adhering to the appropriate technical specifications.

For each measure, HSAG will assign a lead analyst and validation analyst. The lead analyst will develop production code to generate the results and output for performance measures. After the lead analyst completes the analyses, the validation analyst will create separate programming code and compare results with those generated by the lead analyst. Both analysts will work to reconcile any differences in the results before submitting them to the DHCFP. HSAG will check results for reasonability based on available data sources (e.g., comparable benchmarks, historical rates). HSAG has successfully used this process to develop SAS code and calculate rates for a wide array of performance measures, including HEDIS, HEDIS-like, CMS Core Measures, health home, nursing facility, and state-specific measures on behalf of its state Medicaid agency customers.

Report Performance Measure Rates

Once HSAG generates rates, it will provide performance measure rates to the DHCFP in a format determined by the DHCFP. The results will contain numerator and denominator counts, as well as a calculated rate for each measure. The report will also include comparisons to national benchmarks and/or statewide performance standards, where appropriate.

Conduct of PIPs

HSAG understands that conducting PIPs is an optional activity that may be included in the contract resulting from this award and is fully prepared to conduct PIPs in addition to validating those conducted by the MCOs. HSAG has 16 years of experience assisting states and health plans with conducting PIPs and ensures PIPs align with the current CMS protocols and are methodologically sound. For example:

- ***HSAG's PIP team provided guidance and technical assistance to the Georgia Families CMOs to support improvement projects the CMOs conducted in collaboration with the Centers for Disease Control and Prevention (CDC) and the Georgia Department of Community Health (DCH). HSAG reviewed the study design of each CMO's PIP to ensure it was methodologically sound, and provided written feedback on the quality improvement processes and interventions tested. HSAG facilitated collaborative discussions to help the participating CMOs with decision-making.***
- ***In the state of Florida, HSAG's PIP team provided technical assistance and was instrumental in the development of the methodology and State-mandated specifications for each collaborative PIP***

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[4] SAS is a registered trademark of the SAS Institute, Inc.

conducted by the MCOs. The collaborative topics included improving well child visits in the first 15 months of life, six or more visits; improving timeliness of services; and improving follow-up within seven days after acute care discharges for a mental health diagnosis. HSAG facilitated quarterly collaborative conference calls in support of each PIP topic and provided guidance throughout the different stages of the PIP process.

- ***In the State of Illinois, HSAG works collaboratively with the State and MCOs to conduct two PIPs: improving care coordination, and improving follow-up after hospitalization for mental illness. HSAG assisted in the development of the study designs for both topics and currently facilitates on-site quarterly meetings.***

HSAG employs sufficient qualified PIP staff, including CPHQs, clinicians, biostatisticians, healthcare analysts, and measure specialists to perform this activity. The PIP team is certified in the Institute for Healthcare Improvement (IHI) quality improvement science techniques through IHI's open school. HSAG is recognized by CMS for its tools and processes, and the development of a rapid cycle PIP approach.

HSAG is prepared to assist the DHCFP with conducting PIPs using the rapid cycle PIP approach. HSAG will work collaboratively with the DHCFP to determine the topic and narrowed focus for each PIP. HSAG will assist the DHCFP with the development of the specific, measurable, attainable, relevant, and timebound (SMART) Aim of the project, SMART Aim measure, data collection methodology, use of quality improvement tools and processes to identify opportunities for improvement, and the testing of interventions using Plan-Do-Study-Act (PDSA) cycles. HSAG will assist the DHCFP on how to sustain any improvement achieved during the life of the PIP and methods for how to spread successful changes throughout the targeted area for improvement.

In accordance with Amendment 1 to Request for Proposal 3491 issued by the DHCFP on February 2, 2018, HSAG's PIP team is also prepared to validate additional PIPs conducted by the PCCM/CMO related to Pay for Performance measures (P4P). While HSAG understands the DHCFP is preparing to phase out the HCGP, which affects the CMO, HSAG is well-positioned to work with the DHCFP to determine the PIP validation activities that will be needed for a replacement vendor, should one be selected. HSAG has significant experience validating PIPs that aim to improve performance measure rates, such as those in a P4P program. HSAG's validation of P4P PIPs will include an evaluation of the accuracy of the PIP study indicator results reported by the CMO and a determination of the extent to which the specific PIP study indicators calculated by the CMO followed specifications established for the study indicator. This process ensures that HSAG can assess the CMO's ability to produce accurate results while eliminating the redundancy of re-auditing the CMO's data systems and processes. HSAG will determine if any discrepancies exist within the reported PIP data and alert the DHCFP.

Conduct Focused Quality Studies

HSAG understands that focused studies are an optional activity under the contract resulting from this award. HSAG is fully prepared to conduct focused studies on clinical or non-clinical topics of interest to the DHCFP. HSAG has more than 15 years' experience conducting focused studies and clinical record reviews. HSAG has completed or is currently conducting over 60 focused studies in 9 states, including topics such as birth outcomes, opioid use and treatment, tobacco cessation, utilization of EPSDT services, and identification of managed long term services and supports (MLTSS) populations. These have led to measurable outcomes and successful quality improvement initiatives. HSAG has a qualified, multidisciplinary staff to conduct the focused studies, including epidemiologists, biostatisticians, mathematicians, clinical reviewers, and project managers.

HSAG's approach to conducting these studies incorporates EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR), Version 2.0, September 2012. and the highest standards of methodological rigor. The following tasks describe HSAG's general approach to conducting these studies of quality. At a minimum, HSAG's study procedures include, but are not limited to:

- ***Conducting any necessary background research.***
- ***Reviewing population/sample selection criteria.***
- ***Devising data collection methods and tools.***
- ***Performing any relevant data verification and validation.***
- ***Performing appropriate data analysis and interpretation, including provision of tables and graphics.***
- ***Preparing a final report, following standard research reporting guidelines.***
- ***Preparing other deliverables, as directed by the DHCFP, including analytic datasets and presentation materials.***

Please refer to HSAG's response to Section 2.1.5.1A for detailed information regarding HSAG's methodology and approach to focused study validation.

Assistance with Quality Rating System

As described in 42 CFR §438.334, each state contracting with an MCO, PIHP, or PAHP to furnish services to Medicaid members must adopt the Medicaid managed care quality rating system (QRS) developed by CMS or adopt an alternative QRS. The purpose of a QRS is to enable states to better measure and manage the quality of care furnished by managed care organizations and to assist consumers in selecting a managed care organization. By using an easy-to-understand rating scale, a QRS can increase the transparency and accountability for the quality of services provided by managed care vendors. Nevada Medicaid and Check Up members can use these ratings to help them choose a managed care vendor based on vendor performance. States can use these ratings to help inform quality strategy revisions, provide transparency into the managed care program, and allow the states to showcase the accomplishments of its managed care vendors.

HSAG has assisted several state Medicaid agencies (Illinois, Iowa, Michigan, Ohio, Virginia) with the production of their QRS for the past 15 years. For each state, HSAG analyzed HEDIS results CAHPS data from health plans and used these results to create a QRS that provides a comparison of plan performance. The report card shows how each plan does in providing care and services to their members in key performance areas.

Given HSAG's extensive experience in working with state Medicaid agencies to define QRSs, HSAG is poised to successfully assist the DHCFP with the implementing a QRS using CMS' methodology or an alternative methodology. Please refer to HSAG's response to Section 2.1.5.3 for detailed information regarding HSAG's methodology and approach to the QRS.

2.1.3 Validation of MCO, DBA/PAHP and CMO Performance Indicators

2.1.3.1 Performance measures are calculated and submitted annually to the DHCFP by the contracted MCOs; the DBA/PAHP; and the CMO. The Contractor will evaluate the accuracy and the extent to which Medicaid-specific performance measures followed Health Effectiveness Data and Information Set (HEDIS®) Specifications for the calculation of performance measures using one of two methods: 1) A HEDIS® Compliance Audit™ Standards, Policies and Procedures or 2) the Center for Medicare and Medicaid (CMS) Validating Performance Measures Protocol.

HSAG understands and will comply with the requirements set forth in 2.1.3.1.

VALIDATION OF MCO, DBA/PAHP AND CMO PERFORMANCE INDICATORS

HEDIS and Performance Measures Validation Process

HSAG is prepared to validate performance measures that are calculated using the HEDIS specifications by the Nevada managed care vendors in accordance with 42 CFR §438.358(b)(1)(ii). HSAG has extensive experience using the HEDIS Compliance Audit™ Standards, Policies and Procedures, as well as CMS Validating Performance Measures Protocol to determine the extent to which performance measure rates were calculated following the technical specifications.

Performance measure validation ensures that MCOs have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to specifications required by a state. HSAG will tailor its approach to performance measure validation to ensure there is support for the DHCFP's overall goals and objectives of its Medicaid and Check Up programs.

HSAG understands that while certain performance measures are based on HEDIS specifications, not all performance measures used by the DBA/PAHP and the CMO are HEDIS measures that follow HEDIS specifications. HSAG is prepared to conduct HEDIS compliance audits of the MCOs, using the interactive data submission system (IDSS) to submit HEDIS performance measure rates to NCQA. HSAG is prepared to conduct performance measure validation of the DBA/PAHP and CMO, or another vendor should one be selected, following the CMS publication, EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. The certified HEDIS compliance audit HSAG performs for MCOs also aligns with the process outlined in the CMS protocol, but there are extra steps and nuances of a certified HEDIS compliance audit that are not specifically outlined in the CMS protocol, such as the IDSS submission. HSAG assures the HEDIS compliance audit performed for the MCOs meets the requirements outlined in the federal regulations, as well as the CMS protocol. HSAG's proposed approach for the validation of performance indicators activity, using certified HEDIS compliance audits for MCOs and performance measure validation for the DBA/PAHP and the CMO, is described in the following paragraphs. When the HEDIS compliance activity and performance measure validation activity align, HSAG's description will refer to MCOs, the DBA/PAHP, and the CMO (or future vendor) collectively as "vendors." For any deviation, HSAG will specify to which vendor the process refers.

The performance measure validation activity specifically targeted to the CMO vendor is also described in HSAG's response to Section 2.1.5.2.B.

APPROACH TO ACTIVITY

HSAG has already assembled a validation team based on the full complement of skills required to validate the specific performance measures and to conduct the information system review. The validation of performance measures team will be led by Mariyah Badani, MBA, CHCA. Ms. Badani has 15 years of experience in the healthcare industry, working with quality initiatives and performance measure validation. The team will be composed of Ms. Badani, a supporting auditor, a project manager, a source code reviewer, and other supporting team members.

HSAG recognizes that each vendor may be in a different developmental phase, may be staffed differently, and may offer various levels of experience, sophistication and expertise. Therefore, HSAG staff members will work closely with each vendor, before, during, and after the on-site audit to identify the necessary steps to report valid performance measures that follow the measure specifications. To assist a vendor that is struggling with the deadlines, HSAG staff members will participate in frequent conference calls, provide detailed feedback on source code-related issues, and direct the vendor to other external resources to assist with performance measure data collection and reporting.

HSAG will provide the DHCFP with an annual individual report for each vendor. These reports will detail the results of validations, including the findings related to the extent to which the performance measures followed the specifications, recommendations for improvement, requirements for corrective actions, and review of any outstanding required corrective action(s).

2.1.3.2 Verification of methods used to collect HEDIS performance measures. The validation process will be accomplished through methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ Specifications or the CMS Validating Performance Measures protocol. The audit will be conducted for SFY contract years 2019 and each subsequent EQRO contract renewal years.

A. Validation of HEDIS and performance measures reported (as required by the State) during the preceding 12 months.
B. Audited HEDIS Data using Interactive Data Submission System (IDSS). Submit information to NCQA, if applicable.
C HEDIS™ Comparative Analysis for SFY 2019 and each subsequent EQR contract renewal year.
D The awarded vendor is required to submit a comparative analysis and production of a HEDIS report using HEDIS performance measures data submitted by each MCO and DBA/PAHP.

HSAG understands and will comply with the requirements set forth in 2.1.3.2.a through d.

HEDIS AND PERFORMANCE MEASURES VALIDATION PROCESS

Validation of HEDIS and Performance Measures Reported During Preceding 12 Months

HSAG understands the importance of validating the DHCFP-specified performance measure rates that each vendor produces. HSAG also understands the importance of verifying the methods that were used to collect the HEDIS and non-HEDIS performance measure data that represent the vendor's performance during the preceding calendar year.[5] HSAG's audit department possesses the skills and experience necessary to conduct these activities and understand the specific nuances of each vendor

[5] *42 CFR § 438.330(b)(2).*

to ensure the correct process, either HEDIS compliance audit or performance measure validation audit, is followed.

Evaluation of Measure Accuracy and Adherence to HEDIS Specifications

Validation of performance measures is a core competency of the staff at HSAG. The HSAG audit department excels at using acceptable methods to validate performance measures following the CMS protocols and the NCQA HEDIS compliance audit methodology. As an NCQA-Licensed Organization (LO) conducting HEDIS Compliance Audits™ since 1999, HSAG has developed expertise in applying the validation process to a variety of organizations.[6] Understanding that only Certified HEDIS Compliance Auditors (CHCAs) may perform HEDIS compliance audits, HSAG has five CHCAs on staff and has established working relationships with CHCA consultants, who may perform both NCQA HEDIS compliance audits of HEDIS measures and performance measure validation of non-HEDIS measures using the CMS protocols for performance measure validation.

The three major activities associated with performance measure validation and HEDIS compliance audits—pre-on-site, on-site, and post-on-site—are described as follows.

Activity 1: Pre-on-Site Visit Activities

The CMS protocols describe the actions to prepare both the EQRO and the vendor for the on-site portion of the performance measure validation. HSAG will perform the following.

Determine the measure(s) and associated specifications for validation

HSAG will work with the DHCFP to identify the performance measure(s) for validation and to clarify measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification) using the standardized measure specifications. HSAG also will assist in determining the best format to submit the measures.

Prepare the vendor and communicate expectations

HSAG has found it invaluable to emphasize the validation planning process so deadlines and expectations for deliverables are clearly identified and agreed upon. HSAG will provide the vendor with technical assistance to report all required performance measures in a manner suitable for validation. During the initial performance measure validation kick-off call, HSAG will introduce the validation team to the vendor and clearly define roles and responsibilities.

Prepare documentation request

HSAG will provide to the DHCFP for review and approval, a draft documentation request letter and an information collection tool that is appropriate for the audit. The two information collection tools are:

- ***Information Systems Capabilities Assessment Tool (ISCAT), included in the CMS protocols and used for performance measure validation***
- ***Record of Administration, Data Management and Processes (Roadmap), an information collection tool prescribed by NCQA and used to conduct HEDIS compliance audits***

The request letter will detail all required documentation that is needed from the vendor and the associated timelines for completion. Once approved, HSAG will transmit the documentation request and ISCAT/Roadmap to the vendor. HSAG will instruct each vendor to complete either the ISCAT, as

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[6] *NCQA HEDIS Compliance Audit™ is a trademark of NCQA.*

described in the CMS protocols, or the Roadmap, as described NCQA HEDIS Compliance audit protocol, based on the vendor being audited. HSAG will modify the ISCAT, as necessary, to meet the validation requirements.

The ISCAT and Roadmap are information collection tools that inform the auditor about the vendor's information management system. The ISCAT/Roadmap also collect information on data integration and processes used to determine rates for specific measures. The CMS protocols permit auditors to use the NCQA Roadmap in lieu of the ISCAT to collect information about a vendor and to complete the performance measure validation activity. The ISCAT may only be used for performance measure validation and may NOT be used for a HEDIS compliance audit. The ISCAT/Roadmap, along with supporting documentation that accompanies it, collects information about the vendor's membership and healthcare delivery environment, data collection tools, common data formats, data file layouts, and results of any data validation studies.

A review of the vendor's ISCAT/Roadmap information will enable HSAG to prepare for on-site visits and clarify any outstanding issues. HSAG will provide technical assistance to each vendor, as needed, to complete the ISCAT/Roadmap and will work to minimize any burden that might be placed on the vendor's staff to complete the documentation request. HSAG has a secure file transfer protocol (FTP) site for the State and each vendor to transfer data and other documents related to the validation activity.

Conduct CAHPS® sample frame validation

Because some of the NCQA HEDIS-based measures can only be captured through a CAHPS survey, HSAG validates the sample frame for the CAHPS survey in accordance with the most recent version of NCQA's HEDIS, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures. The sample frame validation includes a review of specific reporting methods used for HEDIS/CAHPS measures, including:

- ***Detailed evaluation of the computer programming (source code) used to generate the survey sample frame, ensuring its compliance with specifications for survey measures. If the sample frame is generated using a vendor whose measures were certified by NCQA, HSAG ensures the sample frame method receives a Pass status.***
- ***Detailed review of the survey sample frame file elements to verify compliance with the required layout specified in NCQA's current Volume 3: Specifications for Survey Measures, and the measure-specific eligibility flags were present as applicable.***
- ***Evaluation of membership data completeness.***
- ***Verification the vendor's survey was administered by an NCQA-Certified HEDIS survey vendor.***

HSAG completes the CAHPS sample frame validation activity as part of the MCO HEDIS compliance audit activities.

Review source code

In addition to the ISCAT/Roadmap responses, HSAG will obtain from the vendor the detailed source code and programming logic used to calculate each measure. HSAG programmers, assigned according to familiarity and expertise with the programming language used by each vendor, will conduct a detailed review of each line of code to ensure strict compliance with measure specifications, identify and estimate any potential bias, and identify any necessary corrections.

Assess integrity of the vendor's information systems (IS)

Completing an IS capabilities assessment is a critical validation task that provides valuable feedback to the DHCFP and the vendor on the integrity of the information system and the completeness and accuracy of the data produced by that system. As part of the ISCAT/Roadmap, HSAG will receive detailed information regarding all data systems that feed into the collecting and reporting of performance measures, including patient data, provider data, claims/encounter data, survey data, and data integration processes. The validation team will review submitted documents to identify system or procedural weaknesses that may impact the accuracy of the performance measure rates. HSAG will review this information before the on-site visit to assist in guiding the team toward specific areas of focus.

Prepare the agenda for the vendor on-site review/interviews

Performing an efficient and effective on-site review requires an agenda that assists the vendor in planning staff participation in interviews, gathering required documentation, and addressing logistical issues, such as arranging locations for reviewers to conduct documentation review and interviews. An agenda establishes the tone and expectations for the on-site visit, so all participants understand the time frames for the review. HSAG will send a final agenda to each vendor no later than two weeks before the on-site visit.

HSAG will conduct ongoing dialogue with each vendor to enable the organization to prepare for the on-site visit adequately and for the visit to be productive. HSAG's approach is supportive and educational with ongoing correspondence.

Activity 2: On-Site Visit Activities

The CMS and NCQA protocols require an on-site evaluation for the validation of performance measures. HSAG will conduct an on-site visit at each vendor as part of the validation activities. The on-site visit will build on the findings from the pre-on-site document review of the information systems, the source code review, and the assessment of data provided. The on-site activities will include a review of systems that collect and create measure-related data and of data integration processes and performance calculation methodologies performed either in-house by the vendor or by its subcontractor. HSAG's on-site review process will include the following activities, as detailed on the agenda.

Conduct opening meeting

The opening meeting will include introductions between the HSAG auditor and the key staff involved in the performance measurement activities. The auditor will explain how he/she will conduct the review and discuss the purpose of the meeting, the required documentation, any queries to be performed, and the sharing of findings with the vendor. Additionally, meeting participants will revisit the agenda and discuss logistics.

Review data management processes

The goal of this session is to determine how the data sources are combined and how the analytic file is produced to report the selected performance measures. Session participants will review backup documentation on data integration and the HSAG auditor will interview staff members regarding software products used during data file production, sampling, and measure computation. The HSAG auditor also will review the data control and security procedures during this session.

Review documentation processes

Documentation review alone is generally insufficient to determine compliance, as content and actual performance of procedures in the documents typically can only be confirmed through interviews with the vendor's personnel. The HSAG auditor will discuss the vendor's documentation processes to collect, store, validate, and report the performance measure data. This session is interactive with key staff members, so the auditor can obtain a complete picture of all steps that generate the performance measures. The interviews will be used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice. The auditor will take notes throughout the interviews to document the review findings. Types of documentation reviewed will include the project work plan, data files, data dictionaries, testing and validation of output files, computer queries, policies and procedures, log files, and database/application manuals.

Evaluate algorithmic compliance

The on-site audit will include a complete information systems assessment that focuses on claims and encounter data, enrollment data, and provider data processing. Additionally, the HSAG auditor will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance. This review ensures rate calculations are performed correctly, all data are combined appropriately, and numerator events are counted accurately.

During this session, the HSAG auditor will use several review techniques, including staff interviews, primary source verification, and observation to examine the data collection and reporting processes.

Report performance measures

HSAG will ensure the vendor has reported the performance measures to the DHCFP using the proper reporting tool and method of delivery, keeping in mind appropriate timelines. The HSAG auditor will ensure all required measures have been reported as specified by the DHCFP and will note any deviations. The vendor will be instructed to correct any issues.

Conduct closing conference

At the end of the on-site visit, HSAG will conduct a summation conference with key staff members. The intent of this meeting will be to summarize preliminary findings and outline the documentation requirements post-site visit.

Activity 3: Post-Site Visit Activities

The focus of the post-site visit activities includes assessing the vendor's corrective actions and the medical record review validation process as follows.

Assess status of vendor corrective actions

HSAG will track the verbal and written exchange of information throughout the audit and provide recommendations to improve or correct deficiencies. Furthermore, HSAG will ensure each issue is resolved and will record the dates the vendor corrected the deficiencies and the date HSAG verified the corrections were made.

Perform medical record review validation

The HSAG medical record review validation team includes experienced registered nurses and professional staff trained in hybrid methodology measure specifications and HIPAA protocols.

Beginning with the audit kick-off call, the medical record review validation team will explain and assist each vendor through each step of the medical record review validation process. HSAG will work closely with each vendor to ensure all obstacles that could impact hybrid reported rates are identified and corrected early in the audit. Understanding the various challenges associated with medical record procurement and abstraction within a tight time frame, the medical record review validation team will provide guidance through the following steps:

- ***Step 1: Participate in the initial pre-audit kick-off call***
- ***Step 2: Review and clarify all ISCAT/Roadmap responses pertaining to the vendor's medical record review process, including reviewer training and quality assurance, medical record procurement approach, and data integration with administrative data and vendor oversight***
- ***Step 3: Conduct a thorough review of the vendor's selected data abstraction tools, functionality, and reviewer instructions***
- ***Step 4: Request and review a convenience sample across all hybrid measures. This activity will take place early during the vendor's medical record review process***

Upon completing the convenience sample review, HSAG's medical record review validation team will provide feedback to the vendor to ensure they are following accurate abstraction practices according to the HEDIS and non-HEDIS hybrid methodology measure specifications. HSAG will:

- ***Provide ongoing support during medical record procurement and abstraction***
- ***Conduct a final over-read review of multiple hybrid measures***
- ***Provide corrective actions***
- ***Assist with the final review of hybrid rates***

Verification of vendor corrections, verification of patient-level detail file, and final rate review

HSAG will notify each vendor of all findings as soon as possible to allow enough time for corrective action, if necessary. Once all requested follow-up items and any corrective actions are resolved, each vendor will receive a final IS Tracking Grid report that shows the result for each item. HSAG will review the final rates to assess data completeness and accuracy. HSAG also will provide the vendor with a results report that includes a comparison of the preliminary rates and the prior two years' rates (if available), and shows how each rate compares with the national HEDIS benchmarks for HEDIS measures. Any significant increase or decrease in rates will be highlighted with the auditor's feedback/questions. During final rate review, HSAG will compare the final rates with the preliminary rates and note any significant changes. If any errors are discovered during preliminary rate review, the auditor will review the final rates to ensure the errors were corrected.

For HEDIS compliance audits, HSAG and the MCOs are required to use the interactive data submission system (IDSS) to report HEDIS rates to NCQA. As part of this process, HSAG will ensure the MRR numerator counts in the IDSS submission(s) and rate templates match the lists the MCO submits in May of each year. For performance measure validation, the HSAG verifies the final rates reported by the vendor in the final rate sheet supplied by HSAG match the MRR numerator counts. If there are any discrepancies noted by HSAG, in either the IDSS or final rate sheet, the auditor will incorporate these findings and require the vendor to make corrections, as needed. If any vendor declines or is unable to revise a noncompliant methodology, the auditor will assess whether the noncompliance affects reporting and will advise the vendor that noncompliance may result in designating the measures Not Reportable (NR). Once the final rates are confirmed for the HEDIS compliance audit, the CHCA applies its auditor-lock to the IDSS, which is then submitted to NCQA. The auditor will include final measure scoring and any recommendations in the final audit report.

Achieving Uniform Scoring

HSAG uses the standardized rating methodology for performance measure validation as outlined in the current CMS protocol. The following is a list of the validation findings and their corresponding definitions used in assigning uniform ratings.

- ***R = Report: The measure was compliant with state specifications.***
- ***NR = Not Reported: This designation is assigned to measures for which (1) the vendor rate was materially biased or (2) the vendor was not required to report.***
- ***NB = No Benefit: The measure was not reported because the vendor did not offer the benefit required by the measure.***

Additional ratings are also assigned to match the NCQA HEDIS compliance audit designations.

The HSAG lead auditor ensures audit team members accurately document their findings and that findings support the rate designations assigned to the measures. Lead auditors confer with each other and debrief after each audit to confirm that each review is consistent in processes, findings, and scores across the various audit teams and across organizations. HSAG also subjects each report to a validation process that reviews for accuracy of scoring and analytic content, and for consistency across reports.

Report findings

Following the DHCFP's review and approval of the organization-specific draft reports each year, HSAG will provide the vendor with their respective preliminary findings and draft performance measure validation reports, which will incorporate audit findings from the pre-on-site, on-site, and post-site visit activities. The report will consist of a description of the audit process and methodology, a review of standards and data sources, and recommendations for data collection and analysis. The measure validation section will include methods used to obtain documentation, an evaluation of information systems, measure-specific findings, the process to review final reported rates for potential bias, and aggregate and categorical review findings. The report will detail information system capabilities for performance measure data collection and will discuss additional data sources that could potentially be used for future performance measure reporting.

HSAG also will present results of any corrected programming logic, including corrections to numerators, denominators, or sampling used for final measure calculation, as well as any required corrective actions. HSAG will include in the report a summary of major problems identified, corrective actions identified and implemented, follow-up on the corrective action results, and other recommendations to improve the quality of the vendor's data.

In addition, HSAG will present rate results indicating whether the validated measure is reportable or not reportable (due to a material bias in the calculated rate for a measure). Once approved, the DHCFP and each vendor will receive final organization-specific reports. HSAG's final audit reports comply with all NCQA HEDIS compliance audit standards and CMS validation of performance measures reporting requirements, and they provide the vendor with valuable feedback and actionable recommendations for improving performance measure data collection and reporting activities. HSAG will include in the reports the performance measure rate trends and compare those results to national HEDIS and other benchmarks.

HSAG can modify some of the above activities or include additional steps based on the DHCFP's reporting specifications. HSAG's approach to conducting audits allows for quick adjustments based on each state's requirements to modify the report process as needed.

AUDITED HEDIS DATA USING INTERACTIVE DATA SUBMISSION SYSTEM (IDSS)

At the end of the HEDIS compliance audit performed for an MCO and after the MCO implements any corrective actions provided by HSAG based on the validation activities, HSAG will ensure all audited HEDIS data are submitted to NCQA using the IDSS. HSAG will review the organization's final rates before submission to NCQA via the IDSS to assess data completeness and accuracy, and ensure the MRR numerator counts in the IDSS submission(s) and rate templates match the lists the MCOs submit each year.

As part of this review, HSAG also will issue a findings report to the MCO that includes a comparison of the preliminary rates and the prior two years' rates (if available), and shows how each rate compares with the national HEDIS benchmarks for HEDIS measures. Any significant increase or decrease in rates will be highlighted with the auditor's feedback/questions. During final rate review, HSAG will compare the final rates with the preliminary rates and note any significant changes. If any errors are discovered during preliminary rate review, the auditor will review the final rates and work with MCO to ensure the errors were corrected or confirm there are appropriate reasons for the change in rate.

If there are any discrepancies, the auditor will incorporate these findings and require the MCO to make corrections, as needed. If any MCO declines or is unable to revise a noncompliant methodology, the auditor will assess whether the noncompliance affects reporting and will advise the MCO that noncompliance may result in designating the measures Not Reportable (NR) or Biased Rate (BR). The auditor will include this information and any recommendations in the final audit report.

HEDIS Comparative Analysis for SFY 2019 and Subsequent EQR Contract Renewal Years

HSAG is regarded as a national expert in measures development and evaluation, and is the only firm in the country that is both a Medicaid EQRO and a CMS Measure and Instrument Development and Support (MIDS) contractor. HSAG will leverage this expertise, coupled with its HEDIS audit experience, to synthesize the measure rates for SFY 2018-2019 and subsequent years, and derive data-driven recommendations that identify potential areas of focus for the Nevada Medicaid and Nevada Check Up populations. HSAG's comparative analysis will include a presentation of HEDIS performance measure data submitted by the MCOs and audited by HSAG. Specifically, the analysis will include:

- ***Individual MCO and DBA/PAHP HEDIS rates, including trended rates, where available.***
- ***Comparative analysis among MCOs.***
- ***Comparison of MCO HEDIS rates to statewide data and performance targets.***
- ***Comparison of MCO HEDIS rates to national means and percentiles.***
- ***Comparison of DBA/PAHP HEDIS rates to statewide performance targets and national means and percentiles.***

HSAG's comparative analysis also shows the data completeness for each MCO's hybrid performance measures. Hybrid measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record review data. HSAG's comparative analysis shows the HEDIS rates and the percentage of each reported rate that was determined solely through administrative data for the MCOs, which is an indicator of data completeness. HSAG's analysis highlights the data completeness for each MCO. When data completeness is high, it is possible for a MCO to rely on its administrative data to calculate rates on an interim basis. This is helpful for MCOs because it allows the MCOs to evaluate the effectiveness of performance improvement interventions without having to rely on

abstracting information from medical records, which is costly for the MCO and burdensome for providers. In the past, this information has proven valuable to the DHCFP staff members because it informs them as to the potential data completeness in the State's data warehouse since data is submitted to the State in the form of encounters from the MCOs.

HSAG is prepared to conduct an in-depth assessment of performance measure rates produced by each MCO that highlights significant differences in performance among the MCOs. Because the DBA/PAHP is the only vendor of its type furnishing dental benefits to Nevada Medicaid and Check Up members, HSAG recommends the DBA/PAHP performance measure rates be compared to state-defined performance targets so that high and low performance can be discussed in the comparative analysis. HSAG has applied a similar approach to comparisons with national and regional benchmarks for other states. This comparative analysis approach enables HSAG to quantify the performance across multiple vendors.

HEDIS Comparative Analysis Reporting

Historically, HSAG has provided the HEDIS comparative analysis as a chapter of the annual EQR technical report. This approach allows HSAG to present individual MCO HEDIS performance measure rates, as well as provide a comparison of MCO performance, which is a required component of a technical report, as described in 42 CFR §438.364(a)(5). HSAG's comparative analysis also includes a comparison of MCO HEDIS rates to statewide rates and national means and percentiles. The HEDIS comparative section of the EQR technical report also includes MCO-specific conclusions that highlight high and low performance and recommendations for improvement in areas that demonstrate poor performance. Because the DBA/PAHP just began operations in January 1, 2018, performance measure rates for the DBA/PAHP will be available for FY 2019 reporting.

HSAG will collaborate with the DHCFP to determine the layout for HEDIS comparative analysis reporting, which could include a separate HEDIS comparative analysis report, should the DHCFP decide a separate report would be useful.

2.1.3.3	Validation of Performance Improvement Projects (PIPs). The awarded vendor will be required to annually evaluate and validate two clinical PIPs and three non-clinical PIPs for the MCO; and one clinical PIP and one non-clinical PIP for the DBA/PAHP.

HSAG understands and will comply with the requirements set forth in 2.1.3.3.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

As the EQRO for the State of Nevada, HSAG will annually evaluate and validate two clinical PIPs and three non-clinical PIPs for each MCO and one clinical PIP and one non-clinical PIP for the DBA/PAHP. HSAG's PIP validation methodology is based on the current CMS protocols, DHHS, CMS publication, EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.

HSAG's approach to validation includes two key components of the quality improvement process:

1. ***HSAG evaluates the technical structure of the PIP to ensure each MCO and the DBA/PAHP designed, conducted, and reported the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.***

2. ***HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the data collection process, analysis of data, the identification of barriers and failures, and subsequent development of relevant targeted interventions. Through this component, HSAG evaluates how well each MCO and the DBA/PAHP improves its rates by implementing effective processes. HSAG conducts a critical analysis of the quality improvement processes each MCO and the DBA/PAHP used to identify barriers and failures, as well as the processes used to determine, implement, test, and evaluate interventions. HSAG provides detailed feedback based on the findings of this critical analysis. This type of feedback provides each MCO and the DBA/PAHP guidance on how to refine their approach and make mid-course corrections. This process also helps to ensure the PIP is not simply an exercise in documentation, but rather a process fully implemented in a manner that positively affects healthcare delivery and/or outcomes of care.***

In 2014, HSAG developed an approach for implementing and validating performance improvement projects that places greater emphasis on improving both healthcare outcomes and processes through the integration of quality improvement science. HSAG's rapid cycle PIP framework represents a modified version of the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement. Key concepts include the formation of a team; setting aims; establishing measures; determining, selecting, and testing interventions; and sustaining and spreading improvement. The IHI's QI model focuses on accelerating improvement without replacing change models that different organizations may already be using. The core component of the model includes testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory and practice over the course of the improvement project. HSAG selected this framework because it allows broad flexibility, builds on proven quality concepts, and provides a systematic technique to approach an improvement activity.

Because PIPs must meet CMS requirements, HSAG completed a crosswalk of this new framework against the most current CMS protocols. HSAG presented the crosswalk and new framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was needed. CMS provided HSAG with approval to implement this new approach and has received and approved all current versions of HSAG's instructional guide and PIP templates. With HSAG's guidance, Nevada implemented this PIP approach with its MCOs in SFY 2015.

HSAG developed a series of five modules for the MCOs to submit their PIPs, as well as a comprehensive instructional guide to assist them through this process as they conduct the different phases of the PIP. HSAG provides extensive training and technical assistance throughout the process with frequent contact and feedback to ensure projects are well-designed at the onset and provide opportunities for mid-course corrections.

HSAG will use module validation tools to produce validation findings for each module submitted. Each module validation tool has evaluation criteria that align with the CMS protocols for validating PIPs. The MCOs and DBA/PAHP must meet all the validation criteria for Modules 1 and 2 before moving on to Module 3. HSAG will provide significant technical assistance and feedback in the first phase to ensure the basic infrastructure (Modules 1 through 2) is sound before the MCOs and DBA/PAHP may progress to completing and submitting Module 3 (Intervention Determination). HSAG will validate Module 3 and provide written feedback to the MCOs and DBA/PAHP. The MCOs and DBA/PAHP must meet all the validation criteria before progressing to using a series of Plan-Do-Study-Act (PDSA) cycles to test interventions. Modules 4 and 5 (intervention testing and PIP conclusions) will be submitted for

validation following the pre-determined and approved PIP end date allowing time for the MCOs and DBA/PAHP to conduct the final analysis.

HSAG will produce a PIP validation report for each MCO and the DBA/PAHP. The PIP validation report will include the following:

- ***Background information for each PIP topic submitted and validated***
- ***A discussion of all validated modules and the methods used to conduct the validation***
- ***A discussion of the types of data gathered and the sources of data collection***
- ***SMART (specific, measurable, attainable, relevant, and timebound) Aim measure outcomes and discussion of any changes in performance identified***
- ***Critical evaluation of the quality improvement processes conducted, and interventions tested***
- ***Discussion of conclusions drawn, identified strengths, lessons learned, opportunities for improvement, and HSAG's recommendations to improve performance***

The goal of HSAG's PIP validation is to ensure the DHCFP and key stakeholders have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the MCOs and the DBA/PAHP.

2.1.3.4 Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months.

HSAG understands and will comply with the requirements set forth in 2.1.3.4.

VALIDATION OF MCO AND DBA/PAHP NETWORK ADEQUACY

For the past 15 years, HSAG has completed or is currently conducting 44 managed care provider network adequacy assessments across eight states, including Nevada. While specific review topics varied by state and year, the purpose of the reviews has been to ensure that each vendor has adequate provider networks to deliver healthcare services to its managed care members in the coverage areas.

HSAG understands that, as the EQRO for the State of Nevada, it will be required to validate network adequacy for all MCOs and the DBA/PAHP in accordance with 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5). According to the federal regulations for managed care that were released in May 2016, the activity related to 42 CFR §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than one-year from the issuance of the associated EQR protocol. Because CMS's validation of network adequacy EQR protocol has not been published at the time of this response, HSAG understands that it will collaborate with the DHCFP to modify and finalize the validation methodology upon release of the CMS EQR protocol. Further, HSAG will work with the DHCFP to identify the timing of the network adequacy validation activity, and will perform the activity prior to the issuance of the associated EQR protocol, if requested by the DHCFP.

As part of this activity, HSAG will provide a vendor-specific report that summarizes the results for the MCO or the DBA/PAHP. The report will include a summary of HSAG's validation findings, a summary of validation activities conducted and recommendations for improvement.

HSAG's approach to validating network adequacy is the same regardless of the managed care vendor included in the study; therefore, HSAG's description to complete network adequacy validation refers to MCOs and the DBA/PAHP collectively as "vendors." As a general approach, HSAG will use the following key steps to validate network adequacy:

- ***Develop network validation materials (e.g., work plan, methodology, and data collection tools). HSAG's study methodology development will include a review of any existing standards that were developed by the Nevada Department of Insurance (DOI). For those specialties that are not defined by the DOI, HSAG will work with the DHCFP to identify standards that could be used for provider specialties detailed in 42 CFR §438.68(b).***
- ***Develop a crosswalk of MCO provider specialty types for all three MCOs and the FFS program to ensure consistency in categorizing specialty providers.***
- ***Identify data sources and obtain network information from the vendors and the DHCFP. This will include providing technical assistance to the vendors regarding data requirements and data submissions.***
- ***Conduct retrospective and comparative data analyses to validate multiple dimensions of access, including:***
  - ***Network composition, for baseline studies***
  - ***Network capacity***
  - ***Geographic distribution***
  - ***Availability of services, as appropriate.***
- ***Among the MCOs, these analyses may include comparisons across vendors and provider types.***
- ***Produce a network adequacy validation report that details the methodology used for the study and the vendor-specific and statewide findings of the validation.***
- ***Incorporate network adequacy validation findings and recommendations into the annual EQR technical report, as appropriate.***

HSAG's proposed approach for the validation of network adequacy activity is described in the following subsection.

Approach to Network Adequacy Validation

HSAG is aware that CMS has not, at the time of this proposal, published the validation of network adequacy protocols referenced in federal regulation. Upon issuance, HSAG agrees to implement the protocols according to a timeline established in coordination with the DHCFP.

Pending the implementation of the EQR protocol, HSAG recommends a validation approach addressing three key components of network adequacy: network capacity, geographic distribution, and availability of services. Each component is described as follows.

Network Capacity

HSAG uses measures of network capacity to evaluate the potential capacity and network composition of the vendors' provider networks. Specific analyses include calculating provider-to-member ratios and provider statistics (e.g., provider distribution relative to a vendor's clinical profile, specialist distribution, and region-level provider and member counts). HSAG will collaborate with the DHCFP to identify relevant subpopulations in relation to vendor-specific needs and requirements. Subpopulations could include member, provider, or geographic distinctions (e.g., urban, suburban, and rural members). HSAG will compare results to network standards as defined by the DHCFP, as available.

Ratio standards are frequently established for primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), specialty providers, and hospitals. At a minimum, HSAG recommends incorporating all specialty groups identified in the recently revised federal regulations (i.e., 42 CFR Part 438.68):

- ***Adult and pediatric PCPs***
- ***OB/GYNs***
- ***Adult and pediatric behavioral health providers***
- ***Adult and pediatric specialty providers***
- ***Hospital***
- ***Pharmacy***
- ***Pediatric dental providers***

HSAG will collaborate with the DHCFP to identify the appropriate provider specialty types for inclusion in the network capacity analyses for the MCOs and the DBA/PAHP depending on the type of services they provide (i.e., physical, mental, or dental health services).

HSAG will evaluate network capacity results to determine each vendor's compliance with network standards for provider-to-member ratios, as described in the MCO RFP 3260 Section 3.7.5 Access and Availability and DBA RFP 3425 Section 3.6.5 Access and Availability. HSAG will collaborate with the DHCFP to identify or establish standards for provider specialties not already defined.

Geographic Distribution

HSAG uses measures of geographic distribution to evaluate provider distribution relative to the member population to ensure that members, regardless of where they live, have adequate access to healthcare services. HSAG uses Quest Analytics Suite software to review member and provider addresses to ensure they can be geocoded to exact geographic locations (i.e., latitude and longitude). Geocoded member and provider addresses are assembled into datasets used to conduct two spatial-derived analyses:

- ***Percentage of members within predefined access standards***
- ***Average physical distance and duration of travel time to the nearest three providers***

HSAG will use the analytic results to evaluate the extent to which each vendor's provider/member distribution meets specified time/distance standards, and will compare results to the standards for specific provider types to the extent standards are available. HSAG will assess the percentage of vendor members who are within a certain time/distance standard of their nearest providers to determine the level of vendor compliance with the DHCFP's network standards, as defined in the MCO RFP 3260 Section 3.7.5 Access and Availability and DBA RFP 3425 Section 3.6.5 Access and Availability. HSAG will collaborate with the DHCFP to identify the provider types to be included in the time/distance analysis for each MCO and PAHP depending on the type of services they provide. Additionally, HSAG will collaborate with the DHCFP to identify or establish standards for provider specialties not already defined.

Availability of Services

HSAG uses measures of availability of services to evaluate the accuracy of provider data, the actual availability of appointments, and/or the degree to which the most appropriate providers are available for the vendors' members. Specific analyses may include the following:

- ***Assessments of service utilization***
- ***Appointment availability***

- *Validation of provider standards for language, cultural competencies, or physical access*
- *Assessments of alternate access standards granted by the DHCFP to individual vendors*
- *Grievances and appeals/complaints*

Surveys that assess appointment availability/timeliness or provider data accuracy are typically conducted by telephone using either a direct call or secret shopper approach. Because the vendors frequently conduct telephone surveys assessing appointment availability, HSAG will incorporate those findings into the overall network adequacy validation report.

Multi-Year Approach

Table 2.1.3.4-1 that follows outlines the network adequacy validation activities proposed for each contract year. However, HSAG is aware that CMS expects to publish the validation of network adequacy protocol in 2018. Upon issuance of the protocol, HSAG understands that it will collaborate with the DHCFP to modify and finalize the validation methodology to align with the CMS EQR protocol.

Table 2.1.3.4-1: Proposed Validation of Network Adequacy Timeline

Network Adequacy Validation Task	Year 1	Year 2	Year 3	Year 4
Provider composition analysis	X	*	*	*
Develop data dictionary and provider crosswalk	X			
Network capacity analysis	X	X	X	X
Geographic distribution analysis	X	X	X	X
Review of MCO Appointment Availability Surveys	X	X	X	X
Technical assistance	X	X	X	X
Annual health plan-specific network validation reports	X	X	X	X
Review of recommendations from the previous year		X	X	X

** Optional task during the specified year.*

HSAG's multiyear approach to network adequacy validation will allow the DHCFP to focus on building a strong foundation for ongoing provider network validation and establish procedures that facilitate collection and analysis of high-quality provider data. The first year will start with a provider composition analysis and developing a data dictionary and specialty provider crosswalk. These activities will help the DHCFP adequately prepare for future network validation activities by ensuring that the provider specialties are categorized the same way across the MCOs. In year two, HSAG will perform a baseline provider network capacity analysis and geographic distribution analysis in addition to validating the MCOs' appointment availability surveys. The following years will include follow-up analyses of the provider network capacity, geographic distribution, summaries of the MCOs' appointment availability surveys, and a review of recommendations from the previous year(s).

Study Development and Implementation

HSAG will conduct a project kick-off meeting to establish and promote a transparent process that will continue over the life of the project, and will outline the tasks needed to complete the scope of work. To ensure a successful execution, the HSAG validation of network adequacy team leader will work with the HSAG contract manager and the DHCFP project leadership to confirm key project contacts, establish regular status meetings, and determine appropriate lines of communication. The kick-off meeting also will include a requirements-gathering session with the DHCFP staff. Based on this meeting, HSAG will develop a study methodology for the DHCFP's review and approval. Once finalized, the methodology will be used to generate a detailed analysis plan. These documents will provide the foundation to develop and execute all study protocols.

HSAG will coordinate and conduct regular status meetings with the DHCFP's project team to detail tasks completed for each of the project phases, including an overall summary of the project's progress, and outlining upcoming efforts. The status meetings will discuss recommended resolutions to any issues encountered during the period. This process will allow the DHCFP to shape decision-making on critical issues, provide guidance on ongoing efforts, and help resolve problems and challenges throughout the project. Most importantly, the status updates will focus on specific action items and timelines outlined within the approved project work plan to promote the most efficient use of time and resources for all parties.

Data Collection

Network validation activities will begin with data collection, during which HSAG will collaborate with the DHCFP to identify provider and member data required for validation analyses. HSAG understands that its customers use state-specific approaches to maintain and oversee the vendors' provider data. As such, HSAG anticipates working with the DHCFP to determine the degree to which provider and/or member data will be requested directly from the DHCFP, the vendors, or a data processing intermediary. HSAG will ask the DHCFP and all vendors included in the study to submit provider and member data files to HSAG. HSAG will provide technical assistance to any entity that has questions about specific fields and format that HSAG needs to complete network validation analyses.

HSAG will determine overall data quality by reviewing the data files received to ensure the submitted data contain the requested information in the intended format. HSAG will review discrepancies in the submitted data with the DHCFP and will request that the vendor(s) supply corrected files, if necessary. Because multiple resubmissions will impact the timely completion of the study, HSAG will work with the DHCFP to assess limitations inherent to available data and determine the extent to which it will accept resubmissions. Upon completing the preliminary review of the member and provider network files, HSAG will begin the validation activities.

Network Validation Analyses

During the first year the network validation activity is performed, HSAG will conduct a network composition analysis of the vendors' provider data to provide a framework that supports subsequent validation analyses. As part of the network composition analysis, HSAG will describe the adequacy of the service delivery network by compiling the following:

- ***Medicaid enrollment***
- ***Number and types of providers***
- ***Number of providers accepting/not accepting new patients***

Preliminary composition analyses may be conducted to aid HSAG and the DHCFP in creating a data dictionary and provider crosswalk to ensure consistent definitions of provider types and specialties across MCOs. During this preliminary analysis, HSAG will collaborate with the DHCFP to define provider groups to be included in subsequent validation analyses. At a minimum, HSAG recommends including the provider specialties required by the federal managed care regulations:

- ***Adult and pediatric PCPs***
- ***OB/GYNs***
- ***Adult and pediatric behavioral health providers***
- ***Adult and pediatric specialty providers***
- ***Hospitals***
- ***Pharmacies***
- ***Pediatric dental providers***

The following validation analyses will be conducted for the provider groups the DHCFP approves.

In each year following the provider composition analysis and development of the data dictionary and provider crosswalk, HSAG will calculate provider-to-member ratios to evaluate the potential capacity and network composition of a vendor's provider networks. HSAG will work with the DHCFP to define and customize ratio metrics that best explore network capacity (e.g., types of providers and provider status).

In addition to the provider-to-member ratios, HSAG will conduct the time/distance analysis each year the activity is performed. HSAG will use Quest Analytics Suite software to review the member and provider addresses and ensure they can be geocoded to exact geographic locations in terms of latitude and longitude. Once it creates an analytic dataset, HSAG will conduct two spatial-derived analyses: (1) percentage of members within predefined access standards, and (2) average physical distance and duration of travel time to the nearest three providers. The Quest Analytics Suite software calculates the duration of travel time or physical distance between the addresses of members from the member demographic files and the addresses of their nearest providers. HSAG will evaluate the extent to which a vendor's provider/member distribution meets the time/distance standards as defined by the DHCFP.

Ratio and time/distance analyses provide a broad look at provider networks' capacity and distribution, and HSAG recommends that these analyses be conducted each year to provide an understanding of the vendors' networks. Annual monitoring of the results will allow HSAG and the DHCFP to assess if changes that have been implemented based on annual results and recommendations are effective in improving coverage.

HSAG understands that analyzing provider network data alone is insufficient to evaluate the quality of a vendor's network and the adequacy of members' access to services. As such, HSAG recommends tracking patients' access to providers through appointment availability surveys. Because the managed care vendors are contractually required to conduct secret shopper surveys, HSAG will summarize each vendor's survey and evaluate availability through vendor survey findings. This approach will allow HSAG to incorporate appointment availability findings into the network validation report while maintaining efficiency and minimizing provider burden by not duplicating the vendors' surveys.

VENDOR-SPECIFIC REPORTING

HSAG will produce an annual network validation report with results specific to each vendor and comparative results across the three MCOs. Results will be presented using charts, tables, and maps. Prior to drafting the report for each contract year, HSAG will submit a formatted report outline/template to the DCHFP for review and approval. This process will improve overall efficiency for the review/editing process.

Reports will contain, at a minimum, a brief summary of the validation methodologies, analysis results, conclusions, and recommendations. Reports will present analytic results using charts, graphs, maps produced by Quest Analytics Suite software, and written descriptions of the findings for each network adequacy validation activity (i.e., geoanalysis, ratio analysis, and vendors' provider telephone surveys). Reports also will provide a summary of actions the vendors or the DHCFP may have taken in response to recommendations from previous years' reports, as applicable. HSAG will submit the draft reports to the DHCFP for review and approval based on a mutually agreeable project timeline so that the DHCFP's staff will have sufficient time for review. HSAG will then incorporate the DHCFP's feedback and deliver the final report to the DHCFP and vendors in both electronic and hard copy form.

2.1.3.5 Validation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy (QAPIS) in SFY 2019 and each subsequent EQR contract renewal year. The comprehensive quality assessment and performance improvement program must include PIPs; collection and submission of performance measurement data; mechanisms to detect both underutilization and overutilization of services; and mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs as defined by the State in the quality strategy under 438.340.

A. The awarded vendor will evaluate the completeness of the state quality assessment and performance improvement strategy, examining strengths, limitations, and recommending improvements in the description or implementation of the strategy.
B. The awarded vendor will provide technical assistance to the Division as needed to incorporate changes and recommendations for the development of the Quality Strategy and performance tracking tool for the MCOs, DBA/PAHP, and CMO.
C. The evaluation in each year should include information about the State's progress and status of goals; trends in clinical or service quality performance improvement programs; corrective actions and sanctions; progress and status of value based purchasing; and an assessment of the overall structure and process of the State Quality Assessment and Performance Improvement Strategy. Findings from this assessment will be incorporated as a chapter in the EQR Technical Report described below, entitled "External Quality Review Technical Report".
D. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

HSAG understands and will comply with the requirements set forth in 2.1.3.5.A through D.

VALIDATION OF NEVADA DHCFP STATE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY (QUALITY STRATEGY)

For nearly a decade, HSAG has been instrumental in the development, implementation, ongoing evaluation, and revision of the Nevada DHCFP State quality assessment and performance improvement strategy (quality strategy). Gretchen Thompson, HSAG's Nevada EQRO contract manager, is a certified professional in healthcare quality (CPHQ) and provides guidance to Nevada and several other states in the development, maintenance, and revision of state quality strategies to help ensure each strategy aligns with the requirements outlined in 42 CFR §438.340.

Components of the DHCFP Quality Strategy

The purpose of the DHCFP's quality strategy is to establish a comprehensive framework of continuous quality improvement that advances the DHHS priorities to:

- ***Emphasize preventive care, early intervention, appropriate utilization and quality care.***
- ***Enhance continuity of care through integrated medical, behavioral and social care.***
- ***Ensure a medical home for Medicaid and Nevada Check Up recipients.***
- ***Ensure each recipient can access high quality, comprehensive healthcare services within the recipient's service area.***
- ***Maximize efficient models of care delivery that promote best practice and make healthcare more affordable for individuals, families, and the State.***

To measure achievement of the goals and objectives outlined in the quality strategy, HSAG's contract manager has and will continue to assist the DHCFP staff members with identifying performance measures and indicators that serve as quality objectives so the DHCFP may measure improvement.

The objectives are based on nationally recognized performance measures (e.g., HEDIS) that allow HSAG and DHCFP staff members to quantify improvement over time. Using baseline data to calculate the rate for each objective enables HSAG and the DHCFP to calculate performance targets for each objective. HSAG and the DHCFP modify performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs, the DBA, and the CMO.

Critical to the implementation of the quality strategy is the need to define the tools and processes that will be used to assess performance of the managed care programs over time. Specifically, the DHCFP's quality strategy outlines its continuous quality improvement tools and processes, which include:

- ***Performance improvement projects (PIPs).***
- ***Performance measurement data.***
- ***Mechanisms to assure that MCOs, the DBA/PAHP, and the CMO detect both underutilization and overutilization of services.***
- ***Mechanisms to assess the quality and appropriateness of care, including services furnished to members with special healthcare needs.***
- ***Mechanisms to assess the cultural and linguistic needs of the population, with the purpose of reducing health disparities.***
- ***Mechanisms to monitor and evaluate managed care requirements, including contract compliance for the MCOs, the DBA/PAHP, and the CMO.***
- ***Processes to evaluate and revise the quality strategy based on level of achievement of the goals and objectives, as well as new priorities outlined by the DHHS or the Governor's office.***

Evaluating the Completeness of the Quality Strategy

In 2006, CMS advised states on the overall structure and content of a state's quality strategy through the issuance of the Quality Strategy Toolkit for States[7]. The toolkit contained both required and recommended elements that each state's quality strategy should address. HSAG's contract manager worked with the DHCFP staff members to assure that the DHCFP's quality strategy contained both the required and recommended elements noted in the toolkit. In the latest revision of the DHCFP's quality strategy, HSAG provided a crosswalk that listed all required and recommended elements and the applicable document section that addressed each element. This crosswalk enables CMS project officers to quickly verify that all required and recommended elements are addressed and determine the completeness of the quality strategy. As part of the annual evaluation of the quality strategy, HSAG examines the strengths and limitations of the quality strategy and makes recommendations regarding revisions to the description and implementation of the quality strategy are necessary to further the DHCFP's quality objectives.

Providing Technical Assistance and Tracking Performance

HSAG has been providing technical assistance to the DHCFP regarding the quality strategy since the strategy's first revision in 2009. HSAG has worked with the Division to continually evaluate the successes of the DHCFP's quality program and note where improvements could be gained. For example, HSAG recognized that many staff members within the DHCFP were unfamiliar with the quality improvement activities implemented by the MCOs to improve service accessibility and quality. Further, MCOs were not required to produce a corrective action plan that addressed declining

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[7] *Because the document, Quality Strategy Toolkit for States, was released prior to the revision of the federal regulations for managed care released in May 2016, the toolkit is under revision by CMS. Until the new toolkit is released, the toolkit accessible at the following link is the most current available: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-toolkit.pdf*

performance. Using the goals and objectives outlined in the quality strategy as the foundation, HSAG identified high and low performance areas for each MCO and invited each MCO to present its analyses of strengths and weakness, which included:

- ***Successful interventions used to positively impact performance measures, as evidenced by an improvement of five percentage points or more***
- ***Barrier analyses performed to identify the potential causes that impacted performance measures such that they resulted in a significant decline in performance***

The presentations provided by the MCOs fostered ongoing dialogue among HSAG, MCO, and the DHCFP staff members regarding the interventions that had the greatest impact on the Medicaid population. The discussions regarding each MCO's barrier analyses also highlighted unsuccessful strategies employed by the MCOs that required improvement. Further, staff members from the MCOs, the DHCFP, and HSAG discussed State health policies that had the potential to impact performance measures, both positively and negatively. This type of discussion was most useful for the DHCFP staff members who were not necessarily involved in the managed care program, but were involved in the maintenance of State health policies that impacted managed care members. Because the DHCFP and the MCOs found this exercise helpful, HSAG continues to facilitate these discussions on a semi-annual basis and uses information garnered from the annual evaluation of the goals and objectives outlined in the quality strategy to fuel the presentation requests. Please refer to Section VIII – Other Informational Material, Attachment A – External Quality Review Summary Results, pages 24-25 for a sample of the type of presentation HSAG requests of the MCOs.

HSAG developed the Quality Strategy Performance Tracking Tool (also known as the Goals and Objectives Tracking Table) shown in Section VIII – Other Informational Material, Attachment B, QAPI Goals and Objectives Tracking Table to annually track each MCO's performance related to the goals and objectives described in the quality strategy. In October each year, HSAG presents the annual evaluation of the quality strategy and requests presentations from each MCO to address both high and low performance. HSAG updates the Goals and Objectives Tracking Table annually and produces evaluation results in the annual EQR technical report. Section VIII – Other Informational Material, Attachment C – External Quality Review Technical Report contains the State fiscal year (SFY) 2016-2017 EQR Technical Report, which is the most recent EQR technical report produced for the DHCFP.

Annual Evaluation of the Quality Strategy

Each year, HSAG conducts a formal evaluation of the quality strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to members was accomplished. HSAG's evaluation includes an examination of strengths, opportunities for improvement, and recommendations to add, enhance, or modify quality initiatives aimed at improving service delivery, accessibility, and quality. This evaluation provides critical information about the structure of the quality program and process for improving health service quality, access, and timeliness. When opportunities for improvement are identified, HSAG works with the DHCFP and managed care vendor staff members to identify the leading causes for stagnant or declining performance. HSAG also works with the DHCFP staff members to examine State health policies that may impact, either positively or negatively, service delivery, accessibility, and quality of care. For example, through an evaluation of MCO performance of several access-related quality strategy objectives, HSAG and the DHCFP staff members found that a change to the State's transportation policy had unintended consequences on service accessibility, which negatively impacted access-related quality strategy objectives. Through ongoing communication with the DHCFP and MCOS staff

members during the quality strategy evaluation, the leading cause of the declines was identified, along with prioritizing strategies to improve performance.

The MCO contract resulting from RFP 3260 includes a P4P program wherein MCOs may qualify for bonus payments by achieving performance targets set for six HEDIS performance measures. HSAG's annual evaluation will include an assessment of this value-based purchasing strategy by highlighting the level of achievement the MCOs demonstrated for each of the six measures. HSAG will work with the DHCFP to evaluate the MCOs' performance and will recommend new P4P performance measures that address areas where MCO performance is weak. HSAG is also prepared to work with the DHCFP to identify performance measure and targets that can be used for value-based purchasing strategies for the DBA and the CMO, should the DHCFP decide to employ such programs.

HSAG updates the Goals and Objectives Tracking Table annually and produces evaluation results in the annual EQR technical report.

Final Report

HSAG works with the DHCFP to revise the quality strategy every two years, or more often if major programmatic changes occur. During each revision of the DHCFP quality strategy, HSAG's contract manager works with the DHCFP staff members to apply lessons learned from the previous two years and adjust the goals and objectives, as needed. Prior to the issuance of a revision, HSAG supports the DHCFP to ensure public input—from members and other key stakeholders—is considered and included, as appropriate, in the final version. Once the quality strategy is final, HSAG submits the final document to the DHCFP in both PDF and Word electronic formats and provides the DHCFP with a minimum of five (5) color hard copies that are spiral bound. HSAG regularly inquires with the DHCFP managed care and quality leadership if additional hard copies are needed for new staff members who join the DHCFP.

2.1.3.6 Annual External Quality Review Technical Report – The vendor will be required to produce a detailed technical report that must include:

A. Objectives; technical methods of data collection and analysis; description of data obtained, including validated performance measure data for each activity; and conclusions drawn from the data.
B. An assessment of each MCO's and DBA/PAHP's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
C. Recommendations for improving the quality of health care services furnished by each MCO and DBA/PAHP including how the State can target goals and objectives in the quality strategy, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid recipients.
D. Methodologically appropriate, comparative information about all MCOs and DBA/PAHP, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
E. An assessment of the degree to which each MCO and PAHP, has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
F. Revision. States may not substantively revise the content of the final EQR technical report without evidence of error or omission.
G. Availability of information. (1) The State must contract with a qualified EQRO to produce and submit to the State an annual EQR technical report in accordance with paragraph (a) of this section. The State must finalize the annual technical report by April 30th of each year.
H. Each year the Vendor will include a Chapter in the EQR Technical Report summarizing the findings from the assessment of the DHCFP's implementation of the State Quality Assessment, Performance Improvement Strategy and Performance Tracking Tool. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

HSAG understands and will comply with the requirements set forth in 2.1.3.6.A through H.

ANNUAL EQR TECHNICAL REPORT

HSAG has the skills and experience necessary to perform the EQR services outlined in the RFP and to evaluate and report the results of the EQR activities in the annual technical report. HSAG currently performs EQR activities and prepares annual technical reports for Nevada, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Utah, Vermont, and Virginia. Moreover, HSAG has produced the annual technical report for the State of Nevada since 2003.

HSAG structures technical reports according to the federally mandated and optional activities, as described in 42 CFR §438.358 and includes the requirements of an annual technical report that are described in 42 CFR §438.364. HSAG's reports are well received by state agencies and CMS. The following is a quote from CMS based on an evaluation of HSAG's EQR technical report produced for one Medicaid agency:

> ***"In addition to meeting CMS regulation requirements at 42 CFR §438.364, HSAG went above and beyond the requirements to produce a very professional and useful technical report." —CMS***

Approach and Methodology

Approach

HSAG's approach and philosophy for EQR annual reporting is, first and foremost, to comply with 42 CFR §438.358 and 42 CFR §438.364, ensuring the report—a state's deliverable to CMS—meets the federal requirements. HSAG also believes the subject matter experts who perform the EQR activities are in the best position to analyze and evaluate the activity results within the context of all information compiled for the report, and to make meaningful conclusions and recommendations. Finally, HSAG's approach ensures that a state's preferences are taken into consideration in producing a report with format, tone, and an appropriate depth of content to meet the needs of the state and its stakeholders.

HSAG's method to prepare each EQR technical report is iterative and one involving ongoing discussion and collaboration with the DHCFP to ensure the format and content meet the requirements of the DHCFP and CMS. For example, HSAG regularly meets with DHCFP staff to discuss the goals and priorities of the Nevada State quality assessment and performance improvement strategy (quality strategy) so that findings from the annual evaluation of the quality strategy are incorporated in the annual technical report. By working interactively with the DHCFP staff members throughout the analysis and reporting phases of mandatory and optional activities, HSAG can incorporate the DHCFP staff members' preferences and furnish a high-quality report that meets the federal requirements and DHCFP staff members' expectations. HSAG will continue to work collaboratively with the DHCFP in the design of the annual report and display of findings for Nevada.

Methodology

In May 2016, CMS revised the federal regulations for Medicaid and CHIP managed care programs and required that all EQR mandatory activities be applied to prepaid ambulatory health plans (PAHPs) in addition to MCOs. Certain mandatory activities are also applicable to PCCM programs, which is how CMS has designated the Health Care Guidance Program's (HCGP's) CMO. The two activities that are now mandated for PCCM programs include compliance with federal and state standards, and validation of performance measures. The revisions made to 42 CFR §438.364 now mandate that the results of EQR activities performed for PCCM programs must be reported in the annual EQR technical report. Anticipating that this change would occur, HSAG worked proactively with the State of Nevada to not only complete those activities, but to also report them in the annual EQR technical report. The methods for producing the annual EQR technical report described in this section apply to all managed care vendors operating in Nevada, including MCOs, the DBA/PAHP, and the CMO.

Following the federal regulations for reporting EQR activities found in 42 CFR §438.364, HSAG's annual EQR technical report provides details concerning the objectives for each activity, the technical methods of data collection and analysis, a description of the data obtained, the conclusions drawn from the data, an assessment of each MCO's, the DBA/PAHP's, and the CMO's strengths and weaknesses, recommendations for improving the quality of healthcare services furnished by each managed care vendor, methodologically appropriate comparative information concerning each vendor's performance, and an assessment of the degree to which each MCO, the DBA/PAHP, and the CMO effectively addressed the prior year's recommendations made by the EQRO. The following sections provide an explanation of each of the required sections of the EQR technical report.

Objectives of the Activities Included in the EQR Technical Report

In each EQR technical report, HSAG describes the objectives of the EQR activities performed for the DHCFP during the contract year. HSAG also compares the objectives for the individual activities to the State's quality strategy to demonstrate how they support and align with the State's overall quality goals.

Technical Methods of Data Collection and Analysis

To ensure the data are complete and accurate, HSAG's Data Science and Advanced Analytics Division determines the methodology used to collect and analyze the data. HSAG ensures the data are valid and capture the information needed to evaluate each MCO, the DBA/PAHP, and the CMO. The EQR technical report for the Nevada managed care and CMO programs includes a description of HSAG's processes for ensuring the use of appropriate statistical and methodological guidelines to arrive at valid, reliable, and accurate conclusions about each MCO's, the DBA/PAHP's, and the CMO's performance.

Description of the Data Obtained

In each EQR technical report, HSAG describes how it obtained the data for each activity included in the report. The descriptions of the data depend on the activity. For instance, performance measure data may include explanations concerning the eligible population, the sample size, sampling methodology, the vendor data sources, external data sources, exclusion methodology, medical record abstraction methodology, numerators, and denominators. HSAG presents the findings from the data in graphs, tables, or charts, with accompanying detailed narrative explanations that describe the impact on vendor or statewide performance. Confidence intervals also may be included to more accurately compare the rates generated by each MCO, as comparable information will exist for the MCOs only. HSAG compares the rates achieved to available data that could include regional benchmarks, national benchmarks, or specific goals listed in the quality strategy.

Conclusions Drawn from the Data

Within the findings section of the EQR technical report, HSAG summarizes the information specific to each of the EQR tasks, as appropriate, for each MCO, the DBA/PAHP, and the CMO. The findings section details the individual MCO performance, as well as a comparative analysis across MCOs. The findings section also details the performance for the DBA/PAHP and the CMO, as appropriate. HSAG's subject matter experts provide the content for the EQR technical report based on their experience conducting the EQR activities. HSAG describes any cautions that should be considered if limited data are received, if there is less than complete confidence in the completeness and accuracy of the data, if there are differences in the collection methodology used, or if there are differences in the measurement periods. Using regularly updated national databases as the source, HSAG provides meaningful and credible conclusions by comparing performance to established benchmarks.

Assessment of Each MCO's Strengths and Weaknesses

From the data collected, HSAG summarizes each MCO's, the DBA/PAHP's, and the CMO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services provided by each MCO's, the DBA/PAHP, and the CMO. The evaluations are based on the following definitions of quality, access, and timeliness:

- ***<u>Quality</u>: CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its***

enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement."[8]

- ***Timeliness: NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[9] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care)."***
- ***Access: CMS defines "access" in the final rule at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services)."[10]***

Recommendations for Improving the Quality of Healthcare Services Furnished by Each MCO

HSAG uses its comprehensive knowledge of each managed care program and participating vendor, information from statewide and comparative results of EQR activities, and outcomes and trends to make recommendations for each identified weakness or opportunity for improvement. HSAG also draws upon its knowledge of emerging and best practices to make specific and actionable quality improvement recommendations to the DHCFP about the MCOs, the DBA/PAHP, and the CMO. HSAG staff members have the experience to be able to identify statewide or overall program opportunities for improvement and make recommendations for collaborative improvement to overcome systemwide areas of weak performance. For example, in Nevada, HSAG's recommendations have served as the topic area for targeted technical assistance to the MCOs, or as topics for quarterly meetings for the MCOs and the CMO. In previous years, HSAG's EQR technical report recommendations also have been used to develop, revise, or add MCO contract requirements, as well as quality strategy initiatives.

Methodologically Appropriate, Comparative Information Concerning the MCOs' Performance

In the EQR technical report sections, HSAG includes information about the rates each MCO has obtained for each activity that it completes during the calendar year. The rates are compared across MCOs and the statewide aggregate rates. The comparative information about the MCOs is trended over time to reveal if the MCOs are declining, remaining constant, or improving performance in the EQR activity. For example, in the performance measure validation (i.e., HEDIS) section of the SFY 2016-2017 EQR Technical Report, HSAG provided trended performance measure rates for each MCO for HEDIS 2015, 2016, and 2017. Earlier years' performance measure rates were not included because HEDIS 2015 was the first year of data collected after Nevada expanded Medicaid eligibility, which was allowed as part of the Affordable Care Act. Because there is only one DBA/PAHP operating in the

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[8] Federal Register. Code of Federal Regulations, Title 42, Volume 4, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

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

[10] Federal Register. Code of Federal Regulations, Title 42, Volume 4, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

Nevada managed care program, HSAG will provide comparative information between the DBA/PAHP and national means and percentiles, as methodologically appropriate.

Assessment of the Degree to Which Each MCO Addressed Effectively the Recommendations Made by the EQRO in the Prior Year

Even well planned, targeted corrective actions implemented by managed care vendors do not always result in improvement. Managed care vendors often need to re-evaluate and analyze the root causes of deficiencies to achieve improved results. HSAG will review each MCO's, the DBA/PAHP, and the CMO's annual quality evaluation to determine if the recommendations made by HSAG to improve access, quality, and timeliness in the previous year's EQR technical report were addressed by the vendor. Further, HSAG will review each MCO's, the DBA/PAHP, and the CMO's planned quality improvement initiatives documented in the quality improvement work plan to determine if future activities are planned to address opportunities for improvement noted by HSAG.

Annual Evaluation of the State Quality Assessment and Performance Improvement Strategy (Quality Strategy)

Throughout the year, HSAG works closely with the DHCFP to support, oversee, and monitor quality activities and evaluate the Nevada Medicaid program's achievement of goals and objectives outlined in the quality strategy. HSAG will provide ongoing technical support to the DHCFP in the development and monitoring of the quality strategy and will work with the DHCFP to ensure the MCOs, the DBA/PAHP, and the CMO stay informed about new State and federal requirements and evolving technologies for quality measurement and reporting. HSAG will conduct a formal, annual evaluation of the quality strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to members was accomplished. HSAG developed the Quality Strategy Performance Tracking Tool (also known as the Goals and Objectives Tracking Table) shown in Section VIII – Other Informational Material, Attachment B – QAPI Goals and Objectives Tracking Table to annually track each MCO's performance related to the goals and objectives described in the quality strategy. HSAG will update the Goals and Objectives Tracking Table annually and produces evaluation results in the annual EQR technical report. Section VIII – Other Informational Material, Attachment C – External Quality Review Technical Report, contains the State fiscal year (SFY) 2016-2017 EQR Technical Report, which is the most recent EQR technical report produced for the DHCFP.

Preparing and Delivering the Report

To ensure the EQR technical report meets the highest professional standards for quality, organization, accuracy of content, and adherence to federal and DHCFP requirements, HSAG's staff involved in preparing the reports includes subject matter experts, data analysts, technical writers, editors, report production staff members, and managers and directors who oversee the EQR contract for the DHCFP. The EQR technical report includes separate results for the managed care and CMO programs, to the extent they are available. HSAG's expert editing team review all HSAG reports as second-level reviewers to ensure writing quality, completeness, and readability meet the DHCFP's standards. The editing team completes this step prior to sending the DHCFP the draft reports. HSAG welcomes and values feedback on its draft reports and submits draft EQR technical reports electronically in Microsoft Word format to the DHCFP managed care and quality unit, so DHCFP staff members can review the content and provide feedback directly in each document. This feedback enables HSAG to modify the draft report according to the detailed requirements established by the DHCFP. After the DHCFP's feedback is received, HSAG finalizes the report, makes it compliant with Section 508 guidelines for readability, submits the electronic report in Microsoft Word and Adobe PDF formats to the DHCFP.

Lastly, HSAG provides a minimum of three (3) hard copies of the report to the DHCFP by the end of October each year, so the DHCFP may submit its report well in advance of CMS's due date of April 30th.

2.1.4	Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually.

HSAG understands and will comply with the requirements set forth in 2.1.4.

COMPLIANCE REVIEW EVALUATING THE EFFECTIVENESS OF THE QUALITY STRATEGY

One of the mandatory activities described in 42 CFR §438.358 is a review, conducted within the previous three-year period, to determine a MCO's, a DBA/PAHP's, and a PCCM program's compliance with federal and State standards. Because CMS designates the CMO as a PCCM, the federal mandate for compliance reviews also applies to the CMO. To achieve this requirement, HSAG is prepared to conduct an annual on-site compliance review at each MCO, the DBA/PAHP, and the CMO. HSAG understands the DHCFP is preparing to phase-out the HCGP, which affects the CMO. HSAG is well equipped to work with the DHCFP to determine the compliance review activities that will be needed for a replacement vendor, should one be selected. Because the eight-step process for planning, developing review tools, training reviewers, collecting data for the compliance review, preparing for the on-site review, conducting the on-site review, analyzing data, and completing the compliance review report is the same, regardless of the managed care vendor reviewed, HSAG's description that follows refers to MCOs, the DBA/PAHP, and the CMO (or future vendor) collectively as "vendors." For any deviation, HSAG will specify to which vendor the process refers.

Step 1: Planning for Compliance Review Activities

Planning is a vital component to conducting an efficient and effective compliance review. Consequently, the Nevada EQR contract manager collaborates with the DHCFP to customize the approach to the compliance review process to ensure the review meets federal requirements, contract requirements, and the DHCFP's requests and preferences. HSAG is prepared to provide technical assistance and ongoing communication to each vendor and the DHCFP regarding the process, timelines, and expectations to ensure the compliance review process is methodical, well-organized, efficient, and effective.

Beginning in SFY 2017-2018, the DHCFP requested that HSAG conduct annual compliance reviews of the MCOs and the DBA/PAHP thereby eliminating the previous triennial review schedule. HSAG worked with DHCFP staff members to determine an annual compliance review schedule to meet the needs of the DHCFP by reviewing approximately one-third of the standards each year so the full set of federal standards would be reviewed during the three-year cycle, thus meeting the federal requirements. The compliance review schedule for the MCOs and the DBA/PAHP finalized by the DHCFP is illustrated in Table 2.1.4-1 on the following page.

Table 2.1.4-1: Nevada Compliance Review Cycle for MCOs and the DBA/PAHP

Standard	Year 1 MCO-SFY 2017-18 DBA-SFY 2018-2019	Year 2 MCO-SFY 2018-19 DBA-SFY 2019-20	Year 3 MCO-SFY 2019-20 DBA-SFY 2020-21
Provider Network Management			
1. Credentialing and Recredentialing	✓		
2. Availability and Accessibility of Services	✓		
3. Subcontracts and Delegation	✓		
4. Provider Dispute and Complaint Resolution	✓		
5. Provider Information	✓		
Member Services and Experiences			
6. Member Rights and Responsibilities		✓	
7. Member Information		✓	
8. Continuity and Coordination of Care		✓	
9. Grievance and Appeals		✓	
10. Coverage and Authorization of Services		✓	
Managed Care Operations			
11. Internal Quality Assurance Program			✓
12. Cultural Competency Program			✓
13. Confidentiality and Recordkeeping			✓
14. Enrollment and Disenrollment			✓
15. Program Integrity			✓

HSAG will adhere to the defined compliance review schedule and is prepared to work with the DHCFP to develop a similar annual review schedule for the CMO, or another vendor selected by the DHCFP. At the commencement of each year, HSAG will propose a work plan for the compliance review activities and associated timelines that will occur that year. HSAG will determine the dates of the on-site review in collaboration with the DHCFP and vendors being reviewed. Once HSAG confirms the date with the DHCFP, HSAG will notify the HSAG compliance review team and the vendors so that all may prepare for the upcoming reviews. HSAG will stagger the reviews for the MCOs, the DBA/PAHP, and the CMO so they don't all occur at once.

Step 2: Creating Compliance Review Tools

HSAG understands the importance of developing complete and accurate compliance review tools that support comprehensive and objective evaluations of the documents reviewed. HSAG creates the compliance tools from the State-specific requirements found in the vendor contracts with the DHCFP and the associated federal requirements found in 42 Code of Federal Regulations (CFR) §438. Every annual review involves a review of documents that include policies, procedures, reports, meeting minutes, and process information. HSAG has developed compliance review tools, tracking forms, training and interview guides, site visit agendas, file/record review checklists, on-site document

review lists, pre-assessment desk review information lists, and other supportive working papers that have been used, tested, and improved by performing readiness review and compliance review activities for the DHCFP.

The compliance review also includes file reviews to verify the vendor puts into practice what is written in its contract, as well as its policies. HSAG conducts file reviews of member grievances, member appeals, denials of services, credentialing, recredentialing, case management, and delegation oversight. HSAG also uses checklists to review the vendor's contractual compliance for certain documents, such as the member handbook, provider manual, members' rights, and medical record standards related to confidentiality and record keeping.

After HSAG drafts the compliance review tools, the tools will be submitted by the contract manager to the DHCFP for review. The documents sent to the DHCFP may include the policy and procedure review tools, file review tools, checklists, and copies of the correspondence to be sent to the vendors in preparation for the on-site compliance review.

Step 3: Training the HSAG Compliance Review Team

HSAG's compliance review team is led by HSAG's executive director, Gretchen Thompson, who has conducted the compliance review of Nevada managed care vendors since 2009 and who serves as the Nevada contract manager. Ms. Thompson and the compliance review team members have extensive knowledge of current best practices in the industry, Medicaid managed care programs and related regulations, as well as Nevada-specific practice guidelines in the areas of access, structure and operations, and measurement and improvement. The on-site review team chosen for the Nevada compliance reviews includes HSAG staff members with extensive experience in conducting compliance activities for MCOs, DBHA/PAHPs, CMOs, and other managed care vendors. While the HSAG team members have experience conducting compliance reviews in many states, the team will receive information about Nevada-specific contract requirements for each vendor type in preparation for each compliance review. To accomplish this task, HSAG's contract manager conducts a training session for the team. During the training, HSAG reviewers examine prior compliance and readiness review documents and reports. HSAG prepares reviewer training and interview guides to standardize the process for documenting information garnered from the desk review and on-site interviews with vendor staff members. Items covered during the training sessions include:

- ***CMS Medicaid managed care requirements included in the compliance review.***
- ***State-specific requirements included in the compliance review.***
- ***Requirements for any checklists or file reviews included in the compliance review.***
- ***Structure and operation of the Nevada Medicaid managed care programs.***
- ***Instructions concerning the completion of the compliance review tools and reports.***
- ***Timelines associated with the compliance review.***
- ***Sharing of lesson learned from other states and published guidance from nationally recognized organizations as they relate to possible recommendations for the topics included in the compliance review.***

Step 4: Collecting Compliance Review Data from the Vendors

Approximately eight weeks prior to the on-site review, HSAG will send the documents to the vendors. The information includes the DHCFP-approved compliance review tools and detailed instructions for completing the documents that must be submitted to HSAG for the pre-on-site desk review. HSAG also provides information about accessing HSAG's FTP site. The FTP site provides a secure location to upload the review tool and the desk review documents. HSAG's cover letter that describes the

compliance review instructs the vendor to upload all documentation to HSAG's FTP site by a specified date, usually four weeks prior to the on-site review. Once the vendor uploads the information to the HSAG FTP site, HSAG reviewers retrieve files from the FTP site to begin the pre-on-site document review.

HSAG also conducts file reviews during the on-site compliance review (e.g., member grievances, denials of services, member service appeals, case management, or delegation oversight). In the instructions to the vendor to request documentation, HSAG includes requirements to post data files to HSAG's FTP site listing activities that occurred within a specific period. For example, for member grievances, the vendor must provide a list of members who filed a grievance within a specified time period. From those lists, HSAG selects the cases to be assessed during the on-site compliance review.

Within two weeks of HSAG sending the compliance review tools and instructions to vendors, the HSAG compliance review team hosts a webinar with vendors to introduce the various documents that were sent each vendor and to reiterate the process for completing the vendor questionnaire, compliance tool, and for uploading documents to the HSAG FTP site. It is during this webinar that vendor staff members may ask questions and seek clarification about the compliance tools, supporting documentation, the process for uploading information to the HSAG FTP site, and the timelines and logistics associated with the compliance review. HSAG has found that this simple 60- to 90-minute webinar enables vendor staff to better prepare for the on-site compliance review thereby making it a more productive experience for the vendors, HSAG, and the DHCFP.

Step 5: Completing Pre-On-Site Review Activities

After HSAG receives the documents from vendors, the team leader and on-site reviewers begin activities to assess compliance with the federal and State requirements, as described in the subsections that follow.

Pre-On-Site Document Review

Approximately four weeks prior to the on-site review, the HSAG team leader and on-site reviewers begin the pre-on-site or desk review of documents submitted by each vendor. The pre-on-site review, or desk review, enables HSAG reviewers to become familiar with each vendor's structure, staffing, operations, and unique processes. Based on the desk review, HSAG reviewers draft interview questions to be addressed by vendor staff members during the on-site review.

Posting the Agenda and File Review Lists

Approximately one week prior to the on-site review, HSAG posts the agenda and schedules the review for one to two consecutive business days depending on the number of standards and file reviews included in the compliance activities for the year. The agenda lists the proposed date and time for interviews with the vendor's staff members. HSAG always allows the vendor the opportunity to rearrange the interview and file review times to accommodate the needs of its staff members in addition to allowing changes to be made to the agenda while on-site.

Approximately one week prior to the on-site compliance review, HSAG posts to the FTP site the list of the files to be audited during the on-site visit. After HSAG notifies the vendor the lists have been posted to the FTP site, the vendor compiles the documents needed for the file reviews to have the information available on the first day of the on-site review.

Step 6: Completing On-Site Review Activities

Opening Conference and Staff Interviews

The first activity that occurs during the on-site review is the opening conference. HSAG staff members introduce themselves and explain their roles in the on-site compliance review activities. The vendor staff members also introduce themselves and may share information about their plan operations. HSAG staff members review the proposed agenda and on-site activities with the vendor's staff members to determine if any adjustments are needed to the agenda or the proposed interview times.

After the opening conference, the on-site interviews begin. HSAG meets with the key vendor staff members who perform activities associated with each standard to determine the processes for operationalizing the vendor's policies and procedures. HSAG reviewers also ask questions to clarify the information submitted with the pre-on-site documents. HSAG conducts interviews with the vendor staff members to:

- ***Gain a clear and concise understanding of the vendor's compliance with the regulatory requirements.***
- ***Answer questions from the vendor staff members about the review standards.***
- ***Receive clarification concerning any pending questions generated after reviewing the pre-on-site documents.***
- ***Compare the information gained from reviewing the pre-on-site documents to information gained during the interviews.***
- ***Provide the opportunity for HSAG reviewers to request additional relevant documents that may not have been included in the pre-on-site documentation.***
- ***Encourage the vendor's staff members to share any innovative projects undertaken to improve processes or enhance reporting capabilities.***

Collecting Other Accessory Information

HSAG's reviewers continually evaluate additional documentation provided during the on-site reviews. Additional documentation may be in the form of committee minutes, reports, documents, or records that were not submitted prior to the audit. HSAG reviewers log each document submitted by the vendor during the on-site review so it may be referenced later.

When conducting the file reviews, HSAG evaluates the files with a vendor staff member present so the HSAG reviewer may ask the staff member questions and clarify questionable processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the vendor staff member the opportunity to locate the missing information. An element is marked as deficient only if the staff member cannot locate the information needed to satisfy the element on the review tool.

Closing Conference and Exit Interviews

The final activity during the on-site review is the closing conference and the exit interviews. At the end of the on-site visit, HSAG conducts a closing summation with the vendor staff to discuss HSAG's comprehension of information obtained during the compliance review process. Vendor staff members may also answer additional questions and present supplementary documentation to clarify an area of concern noted by HSAG.

During the closing conference, HSAG provides information about the next steps in the compliance review process. Next steps involve analyzing the information obtained during the on-site review and compiling the findings from all the HSAG on-site reviewers. During the closing conference, HSAG

communicates the approximate timeline for submitting the draft report to the DHCFP and the vendor, as well as the process for submitting a remediation or corrective action plan, should one be required.

Step 7: Analyzing and Compiling Findings

HSAG analyzes the information the vendor submits for the desk review, the responses received during the interviews, the findings from the file reviews, and the results of the review of additional documentation presented during the on-site review to determine compliance with each standard and element listed in the compliance review tools. HSAG must be able to validate (via evidence found in the vendor's documents, record reviews, interviews, and various other outcome results) the vendor developed operational policies and processes, followed those processes, and complied with federal regulations and the State's standards and requirements.

After the HSAG reviewers document the findings, the reviewers assign the scores for the compliance review. HSAG analyzes each element within a standard separately and assigns a specific rating for each element. HSAG tallies the ratings for the elements listed in a standard to produce an overall score for each standard. The review team leaders ensure the findings support the scores assigned to each standard. HSAG is diligent in the quality control processes it uses to ensure reviewers are accurate and consistent when documenting the results of the on-site review activities. Team members also discuss their findings to ensure consistency in documenting and evaluating policies and processes, and determining the scores across all standards.

For the Nevada compliance reviews, HSAG uses compliance ratings of Met, Partially Met, or Not Met. This system is supported by the protocols established by CMS in the EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, Version 2.0, dated September 1, 2012, and used in states in which HSAG conducts EQR compliance reviews. If a requirement is not applicable to the vendor for the period covered by HSAG's review, HSAG uses a Not Applicable (NA) scoring designation. During the creation of the compliance tools, HSAG assigns point values to assist in creating a percentage-of-compliance score that can be used to quantify and compare vendor performance, as applicable, provide trending information, and illustrate improvement over time when follow-up reviews are performed. Because there is more than one MCO participating in the managed care program, HSAG will present a comparison of compliance scores across the MCOs in the EQR technical report in addition to individual vendor scores.

Step 8: Reporting Results

After compiling the results from the on-site review and determining the level of compliance with each review element, HSAG creates a comprehensive compliance report that includes a copy of the completed compliance tools used for the review. The compliance tools contain the findings for each element reviewed, as well as a description of the areas that are less than fully compliant that may require remediation or corrective action. HSAG also includes a template the vendor uses to document the proposed corrective action plans for each requirement that did not receive a Met rating.

Prior to releasing the draft compliance review report, the HSAG team lead sends the draft report to HSAG's validation team and professional editors who provide a final check for clarity and accuracy. HSAG ensures the reports are well-written, accurate, and complete. After the editing and final review by the on-site review team, HSAG sends the report to DHCFP staff members, giving them the opportunity to review the report and provide feedback to HSAG. After HSAG receives feedback, HSAG sends the report with the corrective action plan template to the vendor so they may review the report and provide a response to each area that did not receive a Met rating. While the timeline for vendor response to the corrective action plan template varies, HSAG requests the vendor submit the

corrective action plan within two weeks using the template provided in the report. While HSAG facilitates the process for reviewing and accepting the corrective action plans submitted by vendors, the DHCFP maintains ultimate authority for approving vendor corrective action plans.

HSAG will ensure the compliance report is 508 compliant and will provide the reports to the DHCFP and the vendor in hard copy and electronic format. HSAG understands the State retains ownership of all contract deliverables and has the unlimited rights to use, disclose, or duplicate all deliverables produced by the HSAG. To review a copy of the most recent completed compliance review report, see Section VIII – Other Informational Material, Attachment D – Internal Quality Assurance Program (IQAP) On-site Review of Compliance Report.

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.358(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.35f8(c) may include:

2.1.5.1 Nevada Medicaid FFS population activities such as:

A. Clinical focused studies;
B. Healthcare Effectiveness Data and Information Set (HEDIS®) or HEDIS like calculations and audits;
C. Encounter data validation and omission studies; and
D. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

HSAG understands and will comply with the requirements set forth in 2.1.5.1.A through D.

TECHNICAL ASSISTANCE

HSAG provides technical assistance in all 15 states where we serve as the EQRO. HSAG has demonstrated experience providing technical assistance and education related to mandatory activities outlined in 42 CFR §438.358(b), as well as the optional activities outlined in 42 CFR §438.358(c). HSAG provides technical assistance and consulting to state Medicaid agency staff, as well as to various managed care vendors, including MCOs, DBA/PAHPs, CMOs, PCCM vendors, PIHPs, PCMHs, and ACOs. HSAG staff also have experience providing technical assistance for FFS programs.

HSAG has collaborated with the DHCFP to provide technical assistance regarding the DHCFP's managed care program since we first began providing EQR services to the State of Nevada. HSAG's EQR project team, led by Gretchen Thompson, brings a wealth of knowledge and expertise in the areas of performance measure development, validation, calculation, and reporting; performance improvement project facilitation and validation; biostatics and complex analytics; network analyses and validation; managed care rules and regulation interpretation; medical record review; survey development and administration; quality rating system development and deployment; managed care expansion; clinical studies; and encounter data validation.

HSAG's staff members provide specialized technical assistance that resulted in the development and deployment of whole programs. For example, HSAG's staff members provided consultation during the process of negotiating the special terms and conditions (STCs) of the Nevada 1115 research and demonstration waiver with CMS in 2013. The resulting program was the Health Care Guidance

Program (HCGP). HSAG conducted the readiness review and compliance review of the HCGP's CMO and provided technical assistance to the State as part of the corrective action activities that resulted from both reviews. HSAG staff have provided technical assistance to the DHCFP staff members in the form of written communication, conference calls, in-person meetings, written reports, quality strategy development, and 1115 research and demonstration waiver evaluation design plan development. For the managed care program, HSAG's staff members have provided technical assistance to the DHCFP with the selection of performance measures; developing and tracking PIPs and other quality initiatives; developing EQR result summaries to share with DHCFP leadership; identifying national healthcare trends and best-practices that can be shared with MCOs; providing clinical consultation for program evaluation; and providing instruction to MCOs for continuous evaluation and improvement of health initiatives.

The technical assistance provided by HSAG staff members is successful, in large part because of the close interaction and cooperation the HSAG staff establishes among managed care vendors and the DHCFP. HSAG believes a collaborative and educational approach is imperative to conducting the EQR and related activities. With its well-defined process, coupled with the experience of its accomplished staff, HSAG provides consultation, expertise, and recommendations to assist the DHCFP with organizing and completing the mandatory and optional activities defined in federal regulations.

OPTIONAL ACTIVITIES FOR THE MEDICAID FFS POPULATION

While HSAG serves as the EQRO in 15 states, HSAG also has experience working with and performing optional activities for state FFS programs. For example, the Arkansas Division of Medical Services (DMS) contracted with HSAG to develop and manage Medicaid data mining and program evaluation activities for its FFS system. This contract included four activities: data mining and utilization analysis; HEDIS aggregation and calculation; program evaluations; and primary care physician (PCP) and hospital emergency room (ER) utilization profiling. HSAG's projects included a comprehensive evaluation of cesarean delivery rates, validation of federal early and periodic screening, diagnosis and treatment (EPSDT) reporting, implementation of a Children's Health Care Quality Measurement and Improvement Activities (CHIPRA) measure report, hospital readmissions, and emergency department utilization. Additionally, HSAG was involved in calculating and aggregating Arkansas' HEDIS measures.

For the DHCFP's FFS program, HSAG has performed optional activities at the request of the DHCFP. In March 2014, HSAG performed the readiness review of the DHCFP's CMO, which provides care management services to high cost, high needs Medicaid FFS recipients enrolled in the Health Care Guidance Program (HCGP). As part of the CMO readiness review activities, HSAG reviewed the CMO's operational structure to oversee the care coordination of Medicaid covered services to members with multiple chronic conditions. The readiness review included an assessment of the CMO's information system and its capabilities to accept electronic eligibility and enrollment feeds from the DHCFP and prioritize the population into appropriate levels of care coordination as determined by the complex conditions or risk of the population. In December 2014, HSAG completed a compliance review of the CMO, which included a review of the CMO's comprehensive care coordination program to verify the procedures for assessing care coordination needs and providing coordination services were in alignment with nationally recognized guidelines and the CMO's contract. Since 2015, HSAG also performed performance measure validation of the CMO's performance measures, which included assessing the information system for calculating performance measure rates for the CMO's non-P4P performance measures.

HSAG understands the DHCFP is preparing to phase out the HCGP, which affects the CMO. HSAG is prepared to work with the DHCFP to determine the optional activities necessary for a replacement vendor, should one be selected, or for another program that operates within the FFS system.

Clinical Focused Studies

HSAG understands it may conduct focused, one-time studies using methodologies developed in collaboration with the DHCFP to address topics of relevance to quality improvement for the participating MCOs, DBA/PAHP, CMO, and the FFS program. HSAG's approach to focused studies is derived from the EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR). Protocol 8.Version 2.0, September 2012guided by HSAG's experience conducting more than 60 such studies and data mining explorations since 2003. In HSAG's approach will ensure that focused studies address topics of concern to the DHCFP with appropriate scientific rigor, and will include the major steps detailed as follows. Because the process of conducting focused studies is the same regardless of the population or vendor type involved in the study, HSAG's description to complete a focused study for managed care populations refers to MCOs, the DBA/PAHP, and the CMO collectively as "vendors." Focused studies completed for the FFS program will follow the same process, with the caveat that managed care vendors would not be involved.

Develop Study Design

Once notified by the DHCFP of the decision to implement a focused study, HSAG will work with the DHCFP to define the study topic, as well as the scope of work and expected objectives for the study topic. HSAG will then conduct an in-depth literature review to identify best practices for the populations under study and develop a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data collection process, and analytic plan. Because focused studies may require adapting standard healthcare quality measures for applicability to special populations, HSAG's analytic plan will detail the technical specifications for these measures to ensure they are methodologically sound and can be reliably calculated for the populations under study.

Collect Data

After finalizing the methodology for each focused study, HSAG will work with the DHCFP to determine the appropriate data source(s) for the study and develop study-specific data collection approaches to ensure the most appropriate data are extracted for each study and minimize the burden on the DHCFP's data personnel. HSAG will use administrative data supplied by the DHCFP to determine the prevalence rate and any patterns by members' sociodemographic or clinical subgroups for the study topic.

In addition to administrative healthcare claims and encounters, HSAG has extensive experience with using alternate data sources, including, but not limited to, the following:

- ***Birth registry data:*** ***HSAG's focused studies have used data from the 1989 and 2003 versions of the U.S. Standard Certificate of Live Birth as a sole data source, or in conjunction with Medicaid claims/encounters data for measure calculation and data mining activities. Routine studies have linked birth certificate data to Medicaid claims to identify Medicaid-covered births for use in calculating selected CMS Child Core Set measures and birth outcome measures developed by individual states.***
- ***Clinic- or practice-level information:*** ***HSAG has worked with states to develop attribution methodologies for calculating study indicators and HEDIS measures administratively at the clinic***

system and practice levels to allow for comparison of healthcare quality rates and outcomes at a granular level that can enable the State to easily target pilot studies and interventions.

- ***<u>Study-specific vendor surveys:</u> HSAG has worked with states to design custom data collection instruments to elicit qualitative feedback from vendors regarding their data processes, utilization management policies and procedures, and quality improvement efforts.***

Abstract Medical Records, as necessary

The abstraction of medical records is necessary when study designs and measures require the collection and analysis of data that are only available in clinical records. While valuable for investigating clinical practice and the quality of services performed during physician encounters, medical record review studies impact the resources of the vendors, providers, and the DHCFP. HSAG has extensive experience designing and implementing these types of focused studies and will develop a proposal defining the scope of work and study questions.

Similar to focused studies using administrative data, hybrid studies include the development of study methodologies that incorporate a description of the sampling methodology, record review tool, and record abstraction protocol. Drawing on its extensive experience in other states, HSAG has the knowledge and ability to implement these projects. Key steps include:

Sample Selection

The final sample size is selected based on statistical reliability and resource availability. In some cases, HSAG recommends over-sampling for vendor level analyses to account for missing medical records. In these instances, HSAG may recommend weighting the sample proportions to achieve population-level prevalence.

Medical Record Procurement

HSAG has developed a web-based medical record tracking tool, customizable to the DHCFP's parameters, to track procurement compliance. HSAG's record pursuit approach begins with the design of a protocol to identify the provider(s) most likely to possess the required information. Once the record chase protocol is finalized for each sampled case, the provider information will be processed through an address standardization program. HSAG will work with the DHCFP during this time to design a provider informational letter that gives an overview of the study, introduces HSAG as a contractor of the DHCFP, and stresses the importance of provider cooperation to ensure a successful study outcome. The record request packet sent to each provider will include the informational letter (on the DHCFP's letterhead), the list of sampled cases, and the HSAG-designed instructions regarding the required portion of the medical record. In the event a provider has more than one sampled case, he or she will receive a single request listing all sampled cases.

Experience has proven that an initial call to the providers' offices to identify a contact person and fax number dramatically increases the likelihood of provider compliance during the record procurement process. This approach also helps to alleviate returned mail; often the record is immediately faxed back to HSAG by the contact person. HSAG's medical record retrieval process includes the acceptance of scanned medical records; faxed, hard copy medical records obtained through the mail that are subsequently scanned and stored on a secure drive; or electronic submission via a secure FTP site. HSAG staff members are adept at expressing the purpose of a particular study, communicating clearly and professionally with clinical site staff members, and problem-solving to ensure that the needs of the clinical site are met while coordinating record procurement.

HSAG also has an established data collection, management, and reporting system. This system is capable of tracking compliance with medical record procurement, the accuracy of provider addresses,

and the status/location of cases throughout the study. Using its web-based abstraction tool, HSAG can report the progress of record procurement and abstraction at any given time to the DHCFP and the vendors. This system has been used extensively for medical record procurement and abstraction projects over many state EQRO contracts. The ability to accurately and efficiently track the progress of record retrieval and abstraction enables HSAG to adhere to project deliverables and ensure compliance with HIPAA regulations.

Medical Record Abstraction Tool

In additional to the procurement process, HSAG will customize its existing web-based data collection tool to the specific focused study indicators. Because HSAG is an NCQA-licensed audit organization and conducts HEDIS medical record validation across all NCQA hybrid measures each year, tested and validated abstraction instruments and corresponding abstraction instructions are presently available. These instruments can be modified to accommodate revisions to the current HEDIS specifications or collect additional indicators specific to unique populations within Medicaid (e.g., members new to managed care service delivery). HSAG reviewers enter data directly into an electronic tool to achieve greater efficiency and gain the full benefits of real-time validation. Data collection tools are pre-tested for interrater reliability (IRR) and are tested on an ongoing basis. A set of standard checks is run during and after data collection to ensure valid ranges and all logical field-to-field comparisons, and data frequency distributions are validated prior to analysis.

Abstraction

Upon receipt of the medical records, HSAG's clinical abstraction team is responsible for abstracting the information from the records. Within this team comprised of nurses, behavioral health professionals, and medical record coders, each team member has experience with abstracting the HEDIS hybrid measures, as well as measures from the CMS Adult Core Set and Child Core Set. To ensure accuracy of the abstracted data, HSAG conducts an intensive training for the clinical reviewer staff and ensures that each reviewer receives and learns the information about the project in a standardized manner. IRR testing is conducted upon conclusion of training. Each reviewer must score at least 95 percent before beginning "live" abstraction. Following the initial IRR, HSAG conducts ongoing IRR testing throughout the duration of the record review process. Each clinical reviewer must maintain a 95 percent or higher accuracy score throughout the study. Based on established policies and procedures, HSAG's procurement and abstraction process is continually monitored to ensure the validity and accuracy of data being collected. Additionally, HSAG follows the HEDIS compliance audit methodology for medical record validation to ensure validated and accurate data.

Maintaining Confidentiality

HSAG takes confidentiality, the protection of sensitive patient health records, and protected health information very seriously during all stages of data collection, analysis, and reporting. HSAG has implemented a thorough HIPAA compliance and protection program (in accordance with federal regulations) that includes recurring training, as well as policies and procedures that address physical security, electronic security, and day-to-day operations. HSAG takes all necessary steps to ensure its abstraction applications comply with federal and HIPAA standards and regulations for protecting the sensitive health information being collected and stored via its data collection tools. Based on the tool platform (e.g., web-based, MS Access-based), every application is implemented with extensive security measures designed to keep sensitive health information safe. Moreover, the use of the strong password requirements and role-based access and privileges enables HSAG to control the information available to reviewers. Finally, all data file transfers are conducted via FTP and stored on encrypted drives.

Following medical record abstraction, a set of standard edits is run as a final validity check. It includes reviewing the frequency distributions, valid range checks, and all logical field-to-field comparisons. This validation step represents a final review for discrepancies in each variable abstracted from the medical record. The review team project manager assists the HSAG analyst during this final process to ensure integrity of the medical record abstracted data.

Conduct Analyses

HSAG will conduct statistical analyses according to the approved analytic plan. Primary analysis will be conducted to address the study question and provide the results for the study indicators. HSAG also will perform a secondary analysis to examine variations among subgroups (e.g., male and female), patterns of care and outcomes, impact of explanatory variables on the indicators, and the correlation between variables. All analysis and reporting will incorporate comparison between the managed care and FFS populations, as applicable. HSAG is cognizant of the various threats to internal and external validity outlined by Cook & Campbell (1979).[11] In designing each focused study, HSAG will work to ensure that each threat is addressed and minimized to the extent possible. All results generated will be independently validated by another member of the analytic staff.

Produce a Final Report

At the end of each focused study, HSAG will produce a report for the DHCFP that includes an executive summary; study methodology, including the data collection and analysis process; the study results; and conclusions and recommendations. In addition to presenting the findings associated with the study questions, the report will discuss implications of the results considering the policy environment within the State and will produce actionable recommendations for the DHCFP, the MCOs, the PAHP, the CMO, and the fee-for-service program, as applicable, to improve the delivery of healthcare to members. These recommendations may include proposed performance measure development strategies specific to a target population for the topic of interest.

HSAG is committed to delivering timely and actionable focused study reports to the DHCFP. Because study timelines may vary based on study topic and data sources, HSAG will work with the DHCFP at the initiation of the study to develop a timeline that reflects study milestones and deliverables, including different phases of review for the final report. Based on the nature of the study, HSAG may provide vendors with preliminary study results for their consideration upon completion of the study analyses and prior to assembly of the final study report. Based on the DHCFP's direction, HSAG may give the vendors an opportunity to provide feedback on the study findings, and this feedback will be incorporated into the final report, if indicated. HSAG also will ensure the DHCFP is provided the opportunity to review and provide feedback on the draft report within the established time frame and separate from the vendors' review. HSAG will incorporate the DHCFP's feedback into the final, comprehensive, aggregated summary report and submit the report to the DHCFP within the designated time frame.

Calculations of HEDIS and HEDIS-like Performance Measures

HSAG has the staff experience and expertise to perform the activities outlined in Section 2.1.5.1.B, which are:

- ***HEDIS or HEDIS-like measure calculations***
- ***HEDIS or HEDIS-like performance measure validation audits***

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[11] Cook, TD & Campbell, DT. Quasi-experimentation: Design & Analysis Issues for Field Settings. Boston, MA: Houghton-Mifflin, 1979.

HSAG understands that it can only audit performance measures that are not calculated by HSAG. HSAG is prepared to calculate HEDIS or non-HEDIS performance measures for the managed care or FFS programs. HSAG is also prepared to conduct a HEDIS or HEDIS-like audit of any HEDIS or HEDIS-like performance measures that were not calculated by HSAG.

HEDIS or HEDIS-like Performance Measure Calculations

HSAG is prepared to calculate performance measures in accordance with the DHCFP-approved technical specifications and the CMS EQR Protocol 6: Calculation of Performance Measures: Protocol for External Quality Review (EQR), Version 2.0, September 2012. HSAG has 11 years' experience calculating performance measures for eight states (Nevada, Arizona, Arkansas, Colorado, Iowa, New Hampshire, Ohio, Virginia). HSAG has extensive experience calculating a variety of performance measures across multiple health plans and populations, including HEDIS, HEDIS-like, CMS Core Measures, NQF, AHRQ, and custom measures for several state Medicaid agencies. Further, as Nevada's EQRO, HSAG is calculating nine performance measures for the FFS population following HEDIS Technical Specifications for Health Plans, Volume 2. Staff will leverage their knowledge and expertise in calculating HEDIS or HEDIS-like measures to meet the needs of the DHCFP.

HSAG has extensive experience calculating a variety of performance measures across multiple health plans and programs, including HEDIS and HEDIS-like measures for several state Medicaid agencies. HSAG developed and implemented the Performance Measure Platform (PMP) used to calculate HEDIS, HEDIS-like, and other performance measures using administrative, registry, vital statistics, and medical record review data. PMP has been used for performance measure calculations on behalf of several state Medicaid agencies. HSAG will develop a performance measurement worksheet that includes performance measure specifications for each measure selected by the DHCFP for measure calculation. The worksheet will also identify comparative benchmarking sources (e.g., national benchmarks, statewide performance standards), and outlines any other information required to complete the performance measure calculation activity.

To prepare for data collection, HSAG will create a data request document and will convene a meeting to review the data request document with the DHCFP. This data request document will outline the data required for performance measure calculations (e.g., claims/encounter dates of service, provider file, etc.) and describe how HSAG will ensure the DHCFP and any other data providers transmit data to HSAG with appropriate privacy and security safeguards.

As part of the performance measure calculations, HSAG will collect data via a secure transfer mechanism and ensure that all data elements required for performance measure calculation, as defined in the performance measurement worksheet, are present. Next, HSAG will check the data for such items as valid procedure codes, valid diagnosis codes, correct field size and type, and valid date ranges. HSAG also will perform a series of data integrity checks to ensure that it can appropriately link different files and that discrepancies do not exist (e.g., ensure all members, for whom services have been rendered and claims submitted, are also represented within the enrollment files). HSAG will promptly communicate any issues identified with the data sources to the DHCFP and identify appropriate next steps, such as requesting data resubmission. Once HSAG deems all data are usable, it will integrate the data into its performance measure repository.

Upon receipt of clean and accurate data, HSAG will proceed with calculating performance measures. To achieve the most appropriate and cost-effective analysis of performance measure data, HSAG will use SAS® software to perform all analytic activities. HSAG will develop SAS programming code for each performance measure, adhering to the appropriate technical specifications.

For each measure, HSAG will assign a lead analyst and validation analyst. The lead analyst will develop production code to generate the results and output for performance measures. After the lead analyst completes the analyses, the validation analyst will create separate programming code and compare results with those generated by the lead analyst. Both analysts will work to reconcile any differences in the results before submitting them to the DHCFP. HSAG will check results for reasonability based on available data sources (e.g., comparable benchmarks, historical rates). HSAG has successfully used this process to develop SAS code and calculate rates for a wide array of performance measures, including HEDIS or HEDIS-like measures.

Once HSAG generates rates, it will provide performance measure rates to the DHCFP in a format determined by the DHCFP. The results will contain numerator and denominator counts, as well as a calculated rate for each measure. The report will also include comparisons to national benchmarks and/or statewide performance standards, where appropriate.

HEDIS or HEDIS-Like Performance Measure Validation Audits

HSAG is prepared to provide technical assistance to the DHCFP that includes educational sessions to enhance the use of performance measure validation results, healthcare trends, best practices, or associated quality improvement activities identified or discussed during the performance measure validation process. As part of the performance measure validation process, HSAG's audit team discusses impacts of activities and interventions that have had an impact on rates/results. This information, considered with the results of other mandatory and optional EQR activities, may result in recommendations provided in the annual technical report.

Should the DHCFP require HSAG to conduct performance measure validation of FFS performance measures that were not calculated by HSAG, HSAG will use the same standardized performance measure validation process used for the MCOs and the DBA/PAHP, which is also described in Section 2.1.3.1 Validation of Performance Indicators, as well as in Section 2.1.5.2.B for the CMO. HSAG understands the importance of validating the performance measure rates produced for the FFS population so that FFS rates may be compared to MCO performance measure rates. HSAG's audit department has extensive experience related to this work. HSAG is prepared to serve as the NCQA certified HEDIS compliance auditor for the DHCFP.

HSAG's validation process will be comprehensive; it will include the entire process from the initial source code, data and systems review through final reporting. HSAG's process is based on a combined approach of validating HEDIS and non-HEDIS (i.e., HEDIS-like) measures, such as the CMS Core Measure sets as determined by the DHCFP according to the National Committee for Quality Assurance (NCQA) HEDIS timeline.

Because HSAG understands the nuances of validating HEDIS and non-HEDIS measures and the challenges the DHCFP may face when reporting these metrics, HSAG will provide technical assistance to the DHCFP to report meaningful and reliable performance measure data. HSAG also will provide technical assistance to the DHCFP to prepare for reporting and finalizing an appropriate performance measure validation approach that meets the DHCFP's needs while adhering to CMS' protocol. Results will be validated and submitted according to the NCQA HEDIS timeline.

The following activities specify HSAG's proposed approach to comply with the validation of performance measures requirements for the DHCFP fee-for-service population.

ACTIVITY 1: PRE-ON-SITE VISIT ACTIVITIES

The CMS Protocol 2: Validation of Performance Measures describes the actions to prepare both the EQRO and the DHCFP (or its HEDIS vendor) for the on-site portion of the performance measure validation process. The NCQA HEDIS audit process meets the guidelines as required by the CMS protocols. HSAG will:

Determine the measure(s) and associated specifications for validation

HSAG will work with the DHCFP to identify the performance measure(s) for validation and to clarify measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification) using the standardized measure specifications. HSAG also will assist the DHCFP to determine the best format to submit any non-HEDIS measures, such as the CMS core measures, as well as ensure that the HEDIS measures are submitted using the NCQA Interactive Data Submission System (IDSS).

Prepare the DHCFP or its HEDIS vendor and communicate expectations

HSAG will provide the DHCFP or its HEDIS vendor with technical assistance to report all required performance measures in a manner suitable for validation. During the initial performance measure validation kick-off call, HSAG will introduce the validation team to the DHCFP staff and clearly define roles. HSAG will discuss deadlines and expectations for deliverables to ensure all parties have a thorough understanding of the process.

Prepare documentation request

HSAG will provide the DHCFP, for its review and approval, a draft documentation request packet. The request will include all required documentation necessary for the validation process and a timetable for completion. The Roadmap is a collection tool that informs the auditor about the DHCFP's or its HEDIS vendor's information management system and seeks information on data integration and processes used to determine rates for specific measures. Along with supporting documentation that accompanies it, the Roadmap collects information about the DHCFP's system's membership and healthcare delivery environment and the DHCFP's data collection tools, common data formats, data file layouts, and results of any data validation studies. Once the documentation request packet is approved, HSAG will transmit the document request packet and the Roadmap to the DHCFP and the DHCFP's HEDIS vendor, if applicable. HSAG will instruct the DHCFP to complete the Roadmap as required by HEDIS compliance audit standards.

A review of the DHCFP's completed Roadmap documentation will enable HSAG to prepare for the on-site visit and clarify any outstanding issues. HSAG will provide technical assistance, as needed, to complete the Roadmap and will work to minimize any burden that might be placed on the DHCFP's staff to complete the documentation request. HSAG has an FTP site for the State and, if needed, the DHCFP's HEDIS vendor to transfer data and other documents related to the validation activity.

Review source code

In addition to the Roadmap responses, HSAG will obtain from the DHCFP or the DHCFP's HEDIS vendor the detailed source code and programming logic used to calculate each measure. HSAG understands the DHCFP or its vendor may have measures certified by NCQA. HSAG will obtain from the vendor the measure certification received from NCQA, if applicable. For all other measures not certified, HSAG will have source code reviewed by HSAG source code reviewers assigned according to familiarity and expertise with the programming language used by the vendor. The programmers will conduct a

detailed review of each line of code to ensure strict compliance with measure specifications, identify and estimate any potential bias, and identify any necessary corrections.

Assess Integrity of the DHCFP's or its HEDIS Vendor's Information System

Completing the Roadmap is a critical validation task that provides valuable feedback to the DHCFP on the integrity of the fee-for-service information system and the completeness and accuracy of the data produced by that system. As part of the Roadmap, HSAG will receive detailed information regarding all data systems that feed into the collecting and reporting of performance measures, including patient, provider, claims/encounter, survey data, and data integration processes. The HSAG validation team will review submitted documents to identify system or procedural weaknesses that may impact the accuracy of the performance measure rates. HSAG will review this information before the on-site visit to assist in guiding the team toward specific areas of focus.

Prepare the agenda for the DHCFP and/or its HEDIS vendor on-site review/interviews

The HSAG auditor will provide an agenda for the on-site review and interview sessions which will assist the staff to identify staff participants, gather required documentation and address logistical issues, such as arranging locations to conduct documentation reviews and interviews. The agenda will set the tone and expectations for the on-site visit, so all participants understand the time frame for the review. HSAG will send a finalized agenda to the DHCFP and/or its HEDIS vendor no later than two weeks before the on-site visit.

HSAG's supportive and educational approach enables ongoing dialogue with the DHCFP or its HEDIS vendor which allows adequate preparation for the on-site visit.

Activity 2: On-Site Visit Activities

The CMS protocol requires an on-site evaluation for the validation of performance measures. HSAG will conduct one on-site visit at the DHCFP or its HEDIS vendor's location as part of the validation activities. The on-site visit builds on the findings from the pre-on-site document review of the information systems, the source code review, and the assessment of data provided. It will include a review of systems that collect and create measure-related data, data integration processes, and the performance calculation methodologies performed either in-house by the DHCFP or its HEDIS vendor. HSAG's on-site review process will include the following activities, which also will be listed in the on-site agenda:

Conduct opening meeting

The opening meeting will include introductions between the HSAG auditor and the key DHCFP and/or DHCFP's HEDIS vendor staff members involved in performance measurement activities. The HSAG auditor will review the agenda and discuss logistics, the required documentation, any queries to be performed, and the sharing of findings with the DHCFP or the DHCFP's HEDIS vendor.

Review data management processes

This session will determine how the data sources are combined and how the analytic file is produced to report the selected performance measures. Session participants will review backup documentation on data integration and the HSAG auditor will interview staff members regarding software products used during data file production, sampling, and measure computation. The HSAG auditor will also review the DHCFP and its HEDIS vendor's data control and security procedures.

Review documentation processes

The HSAG auditor will discuss the documentation processes used to collect, store, validate, and report the performance measure data. This session is interactive with key staff members, so the auditor can gain a complete understanding of all steps that generate the performance measures. The interviews will be used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice. Throughout the interviews, the auditor will take notes to document the review findings. Types of documentation reviewed will include the project work plan, data files, data dictionaries, testing and validation of output files, computer queries, policies and procedures, log files, and database/application manuals.

Evaluate algorithmic compliance

The on-site audit will include a complete information systems assessment that focuses on claims and encounter data, enrollment data, and provider data processing. Additionally, the HSAG auditor will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance. This review will ensure that rate calculations are performed correctly, all data are combined appropriately, and numerator events are counted accurately.

During this session, the HSAG auditor will use several review techniques, including staff interviews, primary source verification, and observation, to examine the data collection and reporting processes.

Report performance measures

HSAG will ensure the DHCFP HEDIS vendor, if applicable, has reported the performance measures to the DHCFP using the proper reporting tool and method of delivery, keeping in mind appropriate timelines. The HSAG auditor will ensure that all required measures are reported as specified by the DHCFP and will note any deviations. The vendor will be instructed to correct any issues.

Conduct closing conference

At the conclusion of the on-site visit, HSAG will conduct a summation conference with the key DHCFP and its DHCFP's vendor staff members. This meeting will summarize preliminary findings and outline the documentation requirements for any post-site visit validation work.

Activity 3: Post-Site Visit Activities

Medical Record Review Validation

The HSAG medical record review validation (MRRV) team includes experienced registered nurses trained in HEDIS and non-HEDIS hybrid methodology measure specifications and HIPAA protocols. Beginning with the audit kick-off call, the team will explain each step of the medical record review validation process and assist the DHCFP and its HEDIS vendor through the process. HSAG will work closely with the DHCFP and its HEDIS vendor to ensure all obstacles that could potentially impact hybrid reported rates are identified and corrected early in the audit process. The medical record review validation team, understanding the various challenges associated with medical record procurement and abstraction within a tight time frame, will provide guidance through the following steps:

- ***Participate in the initial pre-audit kick-off call***
- ***Review and clarify all Roadmap responses pertaining to the DHCFP or its HEDIS vendor's medical record review process, including reviewer training and quality assurance, medical record procurement approach, and data integration with administrative data and vendor oversight***

- ***Perform a thorough review of the DHCFP or its HEDIS vendor's selected data abstraction tools, functionality, and reviewer instructions***
- ***Request and review a convenience sample across all hybrid measures. This activity will take place early during the HEDIS vendor's medical record review process***

Upon completing the convenience sample review, HSAG's medical record review validation team will give the DHCFP or its HEDIS vendor feedback to ensure that accurate abstraction practices, according to the HEDIS hybrid specifications, are being followed. HSAG will:

- ***Provide ongoing support during medical record procurement and abstraction***
- ***Conduct a final over-read review of multiple hybrid measures***
- ***Provide corrective actions***
- ***Assist with the final review of hybrid rates***

Verification of the DHCFP or its HEDIS Vendor Corrections, Verification of Patient-Level Detail File, and Final Rate Review

HSAG will notify the DHCFP and its HEDIS vendor of all findings as soon as possible to allow enough time for corrective action, if necessary. Once all requested follow-up items and any corrective actions have been resolved, the DHCFP and its HEDIS vendor will receive a final IS Tracking Grid report that shows the result for each item. HSAG will review the final rates produced for the DHCFP to assess data completeness and accuracy. HSAG also will provide the DHCFP and its HEDIS vendor with a findings report that includes a comparison to the preliminary rates and the prior two years' rates (if available), and shows how each rate compares with the national HEDIS benchmarks for HEDIS measures. Any significant increase or decrease in rates will be highlighted with the auditor's feedback/questions. During final rate review, HSAG will compare the rates with the preliminary rates and note any significant changes. If any errors are discovered during the review, the auditor will review the final rates to ensure the errors are corrected.

In addition, HSAG will ensure that the MRR numerator counts entered into the IDSS submission(s) match the lists the DHCFP or its HEDIS vendor submits in May. If there are any discrepancies, the auditor will incorporate these findings and require corrections as needed. If the DHCFP or its HEDIS vendor declines or is unable to revise a noncompliant methodology, the auditor will assess whether the noncompliance affects reporting and will advise the DHCFP and its HEDIS vendor that noncompliance may result in designating the measures Not Reportable (NR). The auditor will include this information and any recommendations in the final audit report.

Produce the DHCFP Performance Measure Validation Report

Before conducting the validation activities for the DHCFP FFS population, HSAG will produce, for the DHCFP's review and feedback, a proposed report template for the DHCFP FFS performance measure validation results report. The template will incorporate audit findings from the pre-on-site, on-site, and post-on-site visit activities. HSAG also will propose that the results of any corrected programming logic be presented, to include corrections to numerators, denominators, or sampling used for final measure calculation, as well as any required corrective actions. After the DHCFP reviews and approves the proposed template and after the conclusion of the performance measure validation activities, HSAG will submit the draft reports to the DHCFP with the preliminary findings and draft performance measure validation reports. In addition, HSAG will present rate results indicating whether the validated measure is reportable or not reportable (due to a material bias in the calculated rate for a measure). Once approved, the DHCFP will receive the final DHCFP HEDIS FFS report.

Issuance of the Final Report

The DHCFP will receive a final performance measure validation report, marking the conclusion of the audit. This report will build upon the earlier, initial report of preliminary findings. The final report will include the audit findings, corrective actions taken to eliminate errors found during the audit, recommendations, and the final auditor-approved rates and results for each of the measures.

HSAG will provide the DHCFP with a HEDIS compliance audit report each year the activity is conducted. The report will consist of a description of the audit process and methodology, a review of standards and data sources, and recommendations for data collection and analysis. The measure validation section will include methods used to obtain documentation, an evaluation of information systems, measure-specific findings, the process to review final reported rates for potential bias, and aggregate and categorical review findings. The report will detail information system capabilities for performance measure data collection and will discuss additional data sources that could potentially be used for future performance measure reporting.

HSAG will include in the report a summary of major problems identified, corrective actions that were identified and implemented, follow-up on the corrective action results, and other recommendations to improve the quality of the data.

The report will include the results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation. Finally, it will present a summary table indicating which measures are reportable or not reportable (due to a material bias in the calculated rate for a measure). HSAG's final audit reports comply with all NCQA HEDIS compliance audit standards and CMS validation of performance measures reporting requirements. The report provides the DHCFP with valuable feedback and actionable recommendations for improving performance measure data collection and reporting activities. HSAG will include in the report the performance measure rate trends and compare those results to national HEDIS and other benchmarks.

HSAG will use a worksheet to track the verbal and written exchange of information throughout the corrective action and final validation process. Furthermore, HSAG will ensure that each issue is resolved and will record the dates of correction and verification. HSAG understands that any problems identified must be reported to the DHCFP so that timely corrections can be made. HSAG is prepared to work with the DHCFP to ensure that deficiencies are identified, appropriate corrective actions are implemented, and issues are rectified as possible, resulting in reportable, accurate performance measure results.

Encounter Data Validation and Omission Studies

HSAG understands that, as the EQRO, it may conduct a study consistent with the CMS EQR Protocol 4: Validation of Encounter Data Reported by the MCO. Protocol 4. Version 2.0. September 2012 to evaluate the accuracy and completeness of the encounter data the contracted vendors submit to the DHCFP. The protocol consists of five activities:

1. ***Review State requirements for collecting and submitting encounter data***
2. ***Review the MCO's capacity to produce accurate and complete encounter data***
3. ***Analyze MCO electronic encounter data for accuracy and completeness***
4. ***Review medical records to confirm findings of analysis of encounter data***
5. ***Submit findings***

In addition, HSAG's approach to conducting encounter data validation (EDV) studies is tailored to address the specific needs of each state by customizing elements outlined in the CMS protocol for

validating encounter data. HSAG has developed a core competency in evaluating encounter data integrity through information systems (IS) review, administrative profiles, comparative analyses of managed care vendor and state Medicaid encounter data, and medical/clinical record review (MRR). HSAG's approach will provide an effective way to identify and confirm the quality of encounter data that Nevada's Medicaid program collects and maintains. Because the process of conducting EDV studies is the same regardless of the managed care vendor type involved in the study, HSAG's description to complete EDV refers to MCOs and the DBA/PAHP collectively as "vendors."

HSAG will coordinate a kick-off meeting with the DHCFP to discuss the overall scope of the project, anticipated timelines, evaluation methodology, and implementation procedures to validate the DHCFP's encounter data for the duration of the contract. This will allow HSAG and the DHCFP to finalize the scope of work included in each annual EDV. After the kick-off meeting and project requirements gathering session, HSAG will draft a formal EDV methodology for the initial contract year, detailing the specific approach for the evaluation and including the timeline, data collection procedures, and analytic methods. Once the DHCFP reviews and approves the methodology, HSAG will develop a corresponding analysis plan to serve as the technical companion document for the EDV methodology. HSAG will organize a conference call with participating vendors to introduce the study and ensure they understand the importance of encounter data quality, as well as HSAG's approach and procedures for the EDV study. This approach is based on the experience and proven success of HSAG's encounter data evaluation programs implemented for numerous state Medicaid agencies and across a variety of program settings.

Approach to Activity and Adherence to EQR Protocols

HSAG currently adheres to the CMS publication, EQR Protocol 4: Validation of Encounter Data Reported by the MCO. Protocol 4. Version 2.0. September 2012. HSAG is aware that CMS expects to publish revised protocols in 2018. Once CMS issues new or revised EQR activity protocols or toolkits, HSAG agrees to implement them according to the timeline established by the DHCFP.

The following steps describe HSAG's approach to conduct EDV for the DHCFP:

Start-Up Task—Conduct Project Kick-Off Meeting and Ongoing Status Meetings

HSAG will conduct a project kick-off meeting to establish and promote a transparent process that will continue over the life of the project, and will outline the tasks needed to complete the scope of work. To ensure a successful execution, HSAG's EDV team leader will work with HSAG's Nevada contract manager and the DHCFP project leadership to confirm key project contacts, establish regular status meetings, and determine appropriate lines of communication. The kick-off meeting also will include a requirements gathering session with the DHCFP's staff. Based on this meeting, HSAG will develop a study methodology for the DHCFP's review and approval. Once finalized, the methodology will be used to generate a detailed analysis plan. These documents will provide the foundation to develop and execute all study protocols.

HSAG will coordinate and conduct regular status meetings with the project team to detail tasks completed for each of the project phases, summarize the project's overall progress, and discuss upcoming efforts. The status meetings will include any issues encountered during the period to discuss recommended resolutions. This process will allow the DHCFP to shape decision-making on critical issues, provide guidance on ongoing efforts, and help resolve problems and challenges throughout the project. Most importantly, the status updates will focus on specific action items and timelines outlined within the approved project work plan to promote the most efficient use of time and resources for all parties.

Conduct a Targeted Encounter Data Information Systems Survey

As with any activity, HSAG customizes its EDV approach to address a state's specific needs and unique aspects of the managed care environment while relying on the standard protocols for validating, monitoring, and managing encounter data. To ensure the collection of critical information, HSAG employs a multistep process that includes document review, developing and fielding of a customized encounter data assessment, and follow-up interviews with key managed care vendor staff members. HSAG recommends initiating any EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by the DHCFP. Documents for review will include data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and the DHCFP's current encounter data submission requirements, among others. The information obtained from this review is important to develop specific study protocols.

A primary purpose of this assessment will be to identify and document existing processes to submit, accept, and maintain encounter data as a baseline for future encounter data quality improvement activities. This assessment will seek to define how each participant in the encounter data process collects and processes encounter data in a way that the flow of the data from the vendors to the DHCFP is understood. HSAG will assess the calculation and reporting of specific vendor performance measures. The evaluation will be key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. Finally, this baseline information will be important to developing a targeted questionnaire to address important topics of interest to the DHCFP.

For vendors that have not undergone a recent IS assessment, HSAG will develop a customized questionnaire in collaboration with the DHCFP to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also will include a review of supplemental documentation regarding other data systems, including enrollment and providers. After a review of the completed assessments, HSAG will conduct follow-up interviews with key vendor information technology personnel to clarify any questions the reviews generate.

Follow-up conference calls also may be used to understand the current uses of encounter data, the upcoming EDV activities, and program priorities and goals regarding the use of encounter data. In total, these reviews will allow HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis, HSAG will be able to provide actionable recommendations to the existing encounter data systems on areas for improvement or enhancement.

Conduct an Administrative Profile: Assessment of Encounter Data Accuracy, Completeness, and Timeliness

Not only is an assessment of data file completeness important to implement policy, interpret results, and establish valid encounter data quality standards, it is also essential to determine whether encounter data are sufficiently robust for more advanced evaluations (e.g., medical record review). These analyses are extremely useful in evaluating the extent to which data are available to conduct future studies. The degree of data file completeness across the vendors will provide insight into the quality of the DHCFP's overall encounter data system and will represent the basis for establishing confidence in reporting and monitoring activities.

To assess data file completeness, two aspects of encounter data will be examined: field validation and field completeness. The CMS protocol defines field validation and field completeness as:

- ***Percentage present:*** ***Required data fields are present in the file and have information in those fields***
- ***Percentage valid:*** ***Data in the fields are of the required types—e.g., numeric fields have numbers, character fields have characters***
- ***Percentage valid values:*** ***The values are the expected values —e.g., valid ICD-10 codes in the diagnosis field***

HSAG, in collaboration with the DHCFP, will select key fields that generally include date of service, beneficiary ID, billing and servicing provider ID, primary and secondary diagnosis codes, procedure code(s), revenue code(s), and national drug codes. All claims/encounter data types (i.e., institutional, professional, pharmacy, and long-term care) will be examined. The results from this baseline analysis can then be used as a foundation for developing short- and long-term goals and performance standards. Additional data studies, conducted with administrative encounter data and enrollment data extracted from the DHCFP's data warehouse, will include an evaluation of encounter timeliness (i.e., claims lag triangle evaluation), encounter completeness (i.e., monthly encounter data volume per 1,000 member months and monthly paid amount per 1,000 member months), and the impact of rejected encounters on completeness and accuracy. Depending on the needs identified by the DHCFP, all analyses can be stratified by service type to provide additional comparative information. Other methods include a cross-sectional or longitudinal comparison of utilization measures and discrepancy analyses of age- and gender-specific diagnoses and procedures (e.g., male members with an encounter for pregnancy).

HSAG will use the encounter data to evaluate the data's accuracy, completeness, and timeliness. HSAG will work with the DHCFP to determine the appropriate time to extract data from the DHCFP's data system to allow enough time for the encounters in the study period to be submitted to the vendors by each vendor's contracted providers, and then transferred to the DHCFP's data warehouse. HSAG also has the capability to accept HIPAA transactions from the vendors and process the encounters through an Electronic Data Interchange translator. HSAG's process will include a subset of edits designed to capture (1) a vendor's overall compliance with submission requirements (e.g., file name conventions), and (2) key encounter data quality elements (e.g., data field compliance and completeness).

Based on the administrative review results, HSAG will assist the DHCFP in identifying areas for improvement, establish baseline results, identify/develop new standards, and enhance existing performance standards for monitoring/reporting purposes. As appropriate, HSAG will draw on its experience working with other state Medicaid agencies to identify peer state programs to help improve the DHCFP encounter data quality monitoring/reporting strategies. States will be identified based on similarities with Nevada in overall program characteristics, encounter data systems, and encounter data quality program goals. Leveraging its national Medicaid presence, HSAG will use its network of contacts to gain access to key information on other states' programs, as necessary. In addition to applicable national standards, HSAG will use the study results to develop recommendations that the DHCFP may consider. Recommendations will focus on three critical areas for monitoring encounter data quality:

- ***Encounter data submission standards***
- ***Encounter data completeness and accuracy of performance metrics***
- ***Encounter data monitoring report structure and content***

Conduct a Comparative Analysis

In HSAG's experience, a useful step prior to medical record review is a comparative analysis. HSAG recommends that a comparative analysis be performed between the DHCFP's encounter data and the data extracted from the vendors' data systems. The goal of this analysis is to evaluate the extent to which encounters submitted to the DHCFP by the vendors are complete and accurate, based on corresponding information stored in the MCOs' data systems. This step corresponds to another important validation activity described in the CMS protocol (i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting). In this activity, HSAG will develop a data requirements document requesting claims/encounter data from both the DHCFP and the vendors and follow up with technical assistance sessions approximately two weeks after distributing the data requirements documents, thereby allowing the vendors time to review and prepare their questions for the sessions.

HSAG will use data from both the DHCFP and the vendors to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represent the same universe of encounters, the data will target the same encounter types submitted to the DHCFP before the same selected date. This anchor date will allow sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHCFP's data warehouse. The encounter types will be selected in collaboration with the DHCFP and will vary based on plan type or benefits covered.

Once HSAG receives data files from both data sources, the analytic team will conduct a preliminary file review to ensure data are sufficient to conduct the evaluation. The preliminary file review will include the following basic checks:

- ***Data extraction—Extracted based on the data requirements document***
- ***Percentage present—Required data fields are present on the file and have values in those fields.***
- ***Percentage valid—Data in the fields are of the required types; e.g., numeric fields have numbers, character fields have characters.***
- ***Percentage of valid values—The values are the expected values; e.g., valid ICD-10 codes in the diagnosis field.***
- ***Evaluation of matching claim numbers—The percentage of claim numbers matching between the data extracted from the DHCFP's data warehouse and the vendors' data submitted to HSAG***

Based on the results of the preliminary file review, HSAG will generate a report that highlights major findings requiring the vendors to resubmit data, as needed.

Once final data have been received and processed, HSAG will conduct a series of analyses. To facilitate the presentation of findings, the comparative analysis will be divided into two analytic sections.

- ***First, HSAG will assess record-level data completeness using the following metrics for each encounter data type:***
  - ***The number and percentage of records present in the vendors' submitted files but not in the DHCFP's data warehouse (record omission)***
  - ***The number and percentage of records present in the DHCFP's data warehouse but not in the vendors' submitted files (record surplus)***
- ***Second, based on the number of records present in both data sources, HSAG will further examine completeness and accuracy for select data elements. The analyses will focus on an element-level comparison for each data element. Element-level completeness will be evaluated based on the following metrics:***

- ***The number and percentage of records with values present in the vendors' submitted files but not in the DHCFP's data warehouse (element omission)***
- ***The number and percentage of records with values present in the DHCFP's data warehouse but not in the vendors' submitted files (element surplus)***

Element-level accuracy will be limited to those records with values present in both the vendors' submitted files and the DHCFP's data warehouse. For a particular data element, HSAG will determine:

- ***The number and percentage of records with the same values in both the vendors' submitted files and the DHCFP's data warehouse (element accuracy)***
- ***The number and percentage of records present in both data sources with the same values for select data elements relevant to each encounter data type (all-element accuracy)***

The selected fields for this analysis will be established in collaboration with the DHCFP; however, standard fields in HSAG's analysis will include date of service, member ID, billing and servicing provider ID, primary diagnosis, procedure code(s), and payment fields. In general, the analysis will be based on claim type because data fields/elements are often dependent on the type of encounters. For example, in addition to date of service and beneficiary ID, an examination of field completeness in the pharmacy file often includes an assessment of additional fields, such as the national drug code field and the drug quantity field. Likewise, an examination of the institutional file will include additional fields, such as the revenue codes and the diagnosis-related group fields.

Conduct Medical Record Review (MRR)

As outlined in the CMS protocol, MRR is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid members' access to and quality of healthcare services. HSAG has extensive experience and proven processes and procedures for using medical and clinical records to validate encounter data across healthcare settings. However, based on its experience and due to the resource-intense nature of this type of study, HSAG recommends that MRRs be conducted once a minimal level of quality has been assessed within a state's encounter data system.

HSAG's MRR activities begin in collaboration with the DHCFP to define the specific audit question. During the initial planning meeting, HSAG and the DHCFP will define the encounter type and data elements that will be targeted in the analysis—e.g., date of service, diagnosis code, and procedure code for professional encounters. HSAG also will request appropriate data files from the DHCFP to generate a statistically valid sample for MRR. Typically, HSAG uses encounter, eligibility, and enrollment data to develop a sample file that represents the population from which the sample will be drawn. Once the sample is selected, HSAG will match the provider associated with the selected date of service for sampled beneficiaries against the master provider demographic file and then distribute the sample cases to each vendor. The vendors will procure and submit the selected medical record documentation to HSAG for review. Additionally, HSAG will develop an electronic tool to track compliance with medical record requests and the accuracy of provider addresses throughout the activity.

HSAG's procurement and abstraction process is based on established policies and procedures and is continually monitored to ensure the validity and accuracy of the collected data. HSAG works collaboratively with its customers to design a procurement process that maximizes effectiveness and decreases the vendor/provider burden. To improve the procurement rate, HSAG will conduct a webinar with the vendors prior to the procurement phase to review the project and procurement protocols. HSAG will solicit vendor/provider feedback on the medical record request process to

facilitate process refinement with the goal of minimizing provider burden. HSAG recommends that vendors submit medical records electronically via secure file transfer protocol to ensure the protection of personal health information; however, HSAG is prepared to work with the DHCFP and the vendors to accommodate alternative procurement methods (such as faxing or hard-copy submissions via regular mail).

HSAG's experienced medical record abstractors and coders will be responsible for abstracting the medical records. To successfully complete the study, the project lead will work with the MRR team (MRT) beginning with the methodology phase. The MRT is involved with the tool design phase, as well as the tool testing to ensure that the abstracted data are complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the MRT will draft an abstraction instruction document specific to the study for training purposes. Concurrent with record procurement activities, the MRT will train the medical record abstractors and coders on the specific study protocols and conduct interrater reliability and rater-to-standard testing. All medical record abstractors and coders must achieve a 95 percent accuracy rate for the training/testing cases before they may review medical records.

During the MRR activity, HSAG's abstractors and coders will collect and document findings in an HSAG-designed electronic data collection tool. The tool will be designed with edits to assist in the accuracy of data collection. The validation will include a review of specific data elements identified in sample cases, which will be selected randomly from the DHCFP's claims/encounter data system and compared to corresponding documentation in the medical record. Interrater reliability among abstractors/coders, as well as abstractor/coder accuracy, will be evaluated regularly throughout the study. Issues and decisions raised during this evaluation process will be documented in the abstraction instruction document and communicated to all abstractors and coders in a timely manner. In addition, HSAG analysts will review the export files from the abstraction tool on an ongoing basis to ensure the abstraction results are complete, accurate, and consistent.

HSAG's validation of encounter data incorporates a unique two-way approach through which encounters are chosen from both the electronic encounter data and from medical records and are subsequently compared with one another. Claims/encounters chosen from the DHCFP's data system will be compared against the medical record, and visit records from the medical record will be compared against the DHCFP's encounter data. This process allows the study to identify services documented in the members' medical records and that are missing from the DHCFP's system, as well as identify surplus encounters present in the DHCFP's data system but not documented in the members' medical records. For services in both data sources, an analysis of coding accuracy and rendering provider verification will be completed. Information that exists in both data sources but whose values do not match will be considered discrepant.

Once the abstraction is complete, HSAG analysts will export the abstraction data and conduct analyses for each vendor. In general, four primary indicators of data completeness and accuracy will be reported: (1) Medical record agreement—encounters present in both the DHCFP's data system and the members' medical record; (2) Medical record omission—encounters present in the DHCFP's data system but not in the members' medical records; (3) Encounter record omission—encounters documented in the members' medical records but not in the vendor's data system; and (4) Erroneous—encounters present in both data sources but which contain incorrect data elements (e.g., diagnoses, procedures, and rendering providers). HSAG will generate a summary report that includes statewide and vendor-specific findings, as well as recommendations for improvement.

Recommended Approach for FY 2018-2019

As the current EQRO for the State of Nevada, HSAG is conducting an information systems review, comparative analysis, and a medical record review in fiscal year (FY) 2017-2018 for Amerigroup Nevada, Inc. and Health Plan of Nevada (HPN). HSAG recommends conducting these same activities for SilverSummit Healthplan in FY 2018-2019. HSAG also recommends collaborating with the DHCFP, Amerigroup Nevada, Inc., and HPN to conduct follow-up interviews with key vendor personnel to review progress on HSAG's findings and recommendations from the FY 2017-2018 EDV activities. HSAG will assist the DHCFP with gathering information related to the operational changes implemented by the MCO vendors in response to the findings and recommendations. Specifically, HSAG will work with these MCO vendors to review the potential root causes of the key issues and request written responses. Once HSAG reviews the written responses, it will work with the DHCFP to determine whether the findings have been addressed (i.e., HSAG will seek to determine whether the changes applied by the vendors support the creation, processing, and submission of complete, accurate, and timely encounter data to the DHCFP).

Because LIBERTY Dental Plan of Nevada, Inc.'s contract began on January 1, 2018, HSAG recommends conducting information systems (IS) review in FY 2018-2019 to identify and document existing processes to submit, accept, and maintain encounter data as a baseline for future encounter data quality improvement activities. Once the information systems review has been completed, HSAG recommends conducting an administrative profile to assess encounter data accuracy, completeness, and timeliness for the DBA/PAHP.

Vendor-Specific Reporting

Before drafting the vendor-specific reports, HSAG will submit a formatted report outline/template to the DHCFP for review and approval. The vendor-specific report outline/template will contain boilerplate language that will be included in all vendor-specific reports. This process will improve overall efficiency for the process. The vendor-specific reports will follow the CMS EDV protocol, to include key findings, conclusions, and recommendations. The statewide results also will be presented in the vendor-specific reports. Based on the findings and on experience working with other customers, HSAG will provide recommendations that are specific and actionable. HSAG will submit the draft vendor-specific reports to the DHCFP for review and approval based on a mutually agreeable project timeline so that the DHCFP's staff will have sufficient time for review. HSAG will then incorporate the DHCFP's feedback and deliver the final, approved reports before the end of each contract year.

CAHPS Surveys

If the DHCFP elects to administer CAHPS surveys, HSAG will develop a scope of work and budget for this activity. The following provides HSAG's general approach to CAHPS Survey activities.

HSAG will work with the DHCFP to identify the most appropriate survey instrument for the Nevada Medicaid FFS population. HSAG will provide all draft survey materials to the DHCFP for review and approval prior to commencing survey activities. HSAG will submit final approved copies of the survey materials to the DHCFP prior to survey administration.

HSAG will develop sample frame instructions that will provide direction on the eligible population to be included in each file, the file layout, and valid values for each element. The DHCFP will provide HSAG with the sample frame files for the eligible members in the FFS population. HSAG will inspect a sample of the file records to check for any apparent problems with the files including valid values and missing data that may impact survey response rates. HSAG will work with the DHCFP to develop a sampling strategy that will meet the reporting needs of the State.

HSAG will work with its subcontractor, DataStat, to administer the CAHPS surveys. HSAG recommends using a mixed-mode methodology, which includes a four-wave mail protocol (two questionnaires and two reminder postcards) followed by telephone follow-up (i.e., computer assisted telephone interviewing [CATI]). The mixed-mode methodology has been shown to improve response rates. In addition, HSAG is fully prepared to administer the surveys in both English and Spanish. A subcontractor-specific toll-free help line will be established and printed on all survey instruments. The toll-free number will be staffed by fully trained employees and answered by a live operator between 6 a.m. and 5 p.m. Pacific Time, Monday through Friday. Operators log questions and answers, and are instructed to transfer respondents to the telephone center for CATI survey administration, if appropriate. HSAG will provide the DHCFP with weekly disposition reports during survey administration.

Following close of the survey and prior to the survey analysis and reporting, the CAHPS survey data will be reconciled and validated. As part of this process, HSAG will evaluate the data for out-of-range responses (i.e.., invalid values), duplicates, and skip pattern issues. HSAG will use SAS® software to perform all analytic activities.[12] SAS software is the only software platform that currently supports the CAHPS macro released and maintained by the AHRQ CAHPS team. As part of its reporting, HSAG can perform the following analyses:

- ***Dispositions and response rates:*** ***A count of the number of completed surveys and response rates for each population***
- ***Demographics:*** ***A break out of the demographic characteristics of respondents to the survey (e.g., age, gender, race/ethnicity, health status)***
- ***NCQA Comparisons:*** ***A comparison of CAHPS scores to NCQA's most recent HEDIS Benchmarks and Thresholds for Accreditation to derive an overall star rating***
- ***Rates and Proportions:*** ***Calculations of top-box rates and response category proportions for each measure***
- ***Trend Analysis:*** ***A trend analysis that compares that current CAHPS results to previous year's results, if applicable***

HSAG will provide a draft copy of the report to the DHCFP for review. Once the DHCFP has reviewed the report and provided feedback, HSAG will incorporate the feedback into a final version of the report. If requested by the DHCFP, HSAG is prepared to make the final report compliant with Section 508 guidelines for readability and will submit the electronic report in Microsoft Word and Adobe PDF formats to the DHCFP.

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2.1.5.2 Nevada Medicaid Care Coordination program activities such as:

A. A comprehensive on-site contract compliance audit of DHCFP's Care Coordination Vendor.
B. Validation of up to 5 Performance Measures for DHCFP's CMO Vendor. The EQRO will conduct the Validation of Performance Measures review in compliance with the CMS Protocol, Validating Performance Measures.

HSAG understands and will comply with the requirements set forth in 2.1.5.2.A through B.

OPTIONAL ACTIVITIES FOR THE MEDICAID CARE COORDINATION PROGRAM

In May 2016, CMS revised the federal regulations for Medicaid and CHIP managed care programs to require that all EQR mandatory activities be applied to prepaid ambulatory health plans (PAHPs) in addition to MCOs. Certain mandatory activities are also applicable to PCCM programs, which is how CMS designates the Health Care Guidance Program's (HCGP's) CMO. The two activities now mandated for PCCM programs include compliance with federal and state standards and validation of performance measures.

HSAG has significant experience working with DHCFP staff to monitor contract compliance and performance of the CMO. HSAG's history working with the DHCFP on CMO-related tasks began in 2012 following the DHCFP's issuance of RFP 1958 to procure the CMO. Soon after, HSAG's contract manager provided consultation to the DHCFP staff members during the process of negotiating with CMS the special terms and conditions (STCs) of the Nevada 1115 research and demonstration waiver—which governs the HCGP. In March 2014, HSAG performed the readiness review of the DHCFP's CMO and in December 2014, HSAG completed the compliance review of the CMO to determine if the CMO fully met the provisions of its contract with the DHCFP. Since 2015, HSAG has validated the CMO's non-P4P performance measures.

HSAG understands the DHCFP is preparing to phase-out the HCGP, which affects the CMO. HSAG is well-equipped to work with the DHCFP to determine the compliance review and performance measure validation activities that will be needed for a replacement vendor, should one be selected. The responses that follow describe HSAG's approach to completing a comprehensive on-site compliance audit, as well as performance measure validation for a new CMO or similar vendor.

Comprehensive On-Site Contract Compliance Audit

Among the mandatory activities described in 42 CFR §438.358 is a review, conducted within the previous three-year period, to determine a MCO's, a DBA/PAHP's, and a PCCM program's compliance with federal and state standards. Because CMS has designated the CMO as a PCCM, the federal mandate for compliance reviews also applies to the CMO. To achieve this requirement, HSAG is prepared to conduct an annual on-site compliance review at the CMO. Because the eight-step process for planning, developing review tools, training reviewers, collecting data for the compliance review, preparing for the on-site review, conducting the on-site review, analyzing data, and completing the compliance review report is the same, regardless of the managed care vendor reviewed, HSAG's description that follows is similar to the one provided in response to Section 2.1.4. Should the DHCFP procure a new CMO or another vendor for a similar program, HSAG is prepared to modify the approach that follows so that it can be used to conduct a readiness review of the new vendor.

STEP 1: PLANNING FOR COMPLIANCE REVIEW ACTIVITIES

HSAG's contract manager will collaborate with the DHCFP staff members to customize the approach to the compliance review process to ensure the review meets federal requirements, contract requirements, and the DHCFP's requests and preferences. HSAG is prepared to provide technical assistance and ongoing communication to the CMO and to the DHCFP regarding the process, timelines, and expectations to ensure the compliance review process is methodical, well-organized, efficient, and effective.

HSAG is prepared to work with the DHCFP to develop a review schedule for the CMO to ensure all applicable federal standards are reviewed within a three-year period. The DHCFP may select an annual review schedule, such as the one followed for the MCOs, so that one-third of standards are reviewed each year. Several options for review cycles are presented in Table 2.1.5.2-1 that follows.

Table 2.1.5.2-1: Review Cycle Options

Review Year	Option 1	Option 2	Option 3
Year 1	1/3 of Standards	1/2 of Standards	1/2 of Standards
Year 2	1/3 of Standards	1/2 of Standards	Follow-up on Corrective Action Plan (CAP)
Year 3	1/3 of Standards	No Review	1/2 of Standards

HSAG will work with the DHCFP to select a review schedule that best suits the DHCFP, even if one of the options presented in the table above requires modification to meet the DHCFP's needs. At the commencement of each review year, HSAG will propose a work plan for the compliance review activities and associated timelines that will occur that year. HSAG will determine the dates of the on-site review in collaboration with the DHCFP and the CMO. Once HSAG confirms the date with the DHCFP, HSAG will notify its compliance review team and the CMO so that preparation activities may begin.

STEP 2: CREATING COMPLIANCE REVIEW TOOLS

HSAG understands the importance of developing complete and accurate compliance review tools that support comprehensive and objective evaluations of the documents reviewed. HSAG will create compliance review tools from the State-specific requirements found in the CMO contract with the DHCFP and the associated federal requirements found in 42 Code of Federal Regulations (CFR) §438. Every annual review encompasses a review of documents that include policies, procedures, reports, meeting minutes, and process information. HSAG's compliance review tools, tracking forms, training and interview guides, site visit agendas, file/record review checklists, on-site document review lists, pre-assessment desk review information lists, and other supportive working papers are used, tested, and improved by performing readiness review and compliance review activities for the DHCFP.

The compliance review will also include file reviews to verify the CMO implements what is written in its contract, as well as its policies. HSAG will conduct file reviews of member grievances and case management files. Additionally, HSAG will use checklists to review the CMO's contractual compliance for certain documents, such as the member handbook, provider manual, members' rights, and medical record standards related to confidentiality and record keeping.

After HSAG drafts the compliance review tools, HSAG's contract manager will submit the tools to the DHCFP for review. The documents sent to the DHCFP may include the policy and procedure review tools, file review tools, checklists, and copies of the correspondence to be sent to the CMO in preparation for the on-site compliance review.

STEP 3: TRAINING THE HSAG COMPLIANCE REVIEW TEAM

HSAG's compliance review team is led by HSAG's contract manager, Gretchen Thompson, who has conducted compliance reviews of the CMO since 2014. Ms. Thompson and the compliance review team members have extensive knowledge of current best practices in the industry, Medicaid care management programs, and related regulations, as well as Nevada-specific practice guidelines in the areas of access, structure and operations, and measurement and improvement. The on-site review team selected for the Nevada compliance reviews includes HSAG staff members with extensive experience in conducting compliance activities for CMOs and other managed care vendors. While HSAG team members have experience conducting compliance reviews in many states, this team will receive information about Nevada-specific contract requirements for the CMO for the compliance review. To accomplish this task, HSAG's contract manager conducts a training session for the team. During the training, HSAG reviewers examine prior compliance and readiness review documents and reports, if available. HSAG prepares reviewer training and interview guides to standardize the process for documenting information garnered from the desk review and on-site interviews with the CMO staff members. Items covered during the training sessions include:

- ***CMS Medicaid managed care requirements for PCCMs.***
- ***State-specific requirements included in the compliance review.***
- ***Requirements for any checklists or file reviews included in the compliance review.***
- ***Structure and operation of the Nevada CMO program.***
- ***Instructions concerning the completion of the compliance review tools and reports.***
- ***Timelines associated with the compliance review.***
- ***Sharing of lessons learned from other states and published guidance from nationally recognized organizations as they relate to possible recommendations for the topics included in the compliance review.***

STEP 4: COLLECTING COMPLIANCE REVIEW DATA FROM THE CMO

Approximately eight weeks prior to the on-site review, HSAG will send the documents to the CMO. The information will include the DHCFP-approved compliance review tools and detailed instructions for completing the documents that must be submitted to HSAG for the pre-on-site desk review. HSAG also provides information about accessing HSAG's FTP site. The FTP site provides a secure location to upload the review tool and the desk review documents. HSAG's cover letter that describes the compliance review will instruct the CMO to upload all documentation to HSAG's FTP site by a specified date, usually four weeks prior to the on-site review. Once the CMO uploads the information to the HSAG FTP site, HSAG reviewers retrieve files from the FTP site to begin the pre-on-site document review.

HSAG also conducts file reviews during the on-site compliance review (e.g., member grievances and case management). In the instructions to the CMO to request documentation, HSAG will include requirements to post data files to HSAG's FTP site listing activities that occurred within a specific period. For example, for member grievances, the CMO must provide a list of members who filed a grievance within a specified period of time. From those lists, HSAG will select the cases to be assessed during the on-site compliance review.

Within two weeks of HSAG sending the compliance review tools and instructions to the CMO, the HSAG compliance review team will host a webinar with the CMO to introduce the various documents that were sent to the CMO and to reiterate the process for completing the questionnaire, compliance tool, and for uploading documents to the HSAG FTP site. It is during this webinar the CMO staff members may ask questions and seek clarification about the compliance tools, supporting

documentation, the process for uploading information to the HSAG FTP site, and the timelines and logistics associated with the compliance review. HSAG has found that this simple 60- to 90-minute webinar enables vendor staff to better prepare for the on-site compliance review thereby making it a more productive experience for the CMO, HSAG, and the DHCFP.

STEP 5: COMPLETING PRE-ON-SITE REVIEW ACTIVITIES

After HSAG receives the documents from the CMO, the team leader and on-site reviewers will begin activities to assess compliance with the federal and State requirements, as described in the subsections that follow.

Pre-On-Site Document Review

Approximately four weeks prior to the on-site review, the HSAG team leader and on-site reviewers will begin the pre-on-site or desk review of documents submitted by the CMO. The pre-on-site review, or desk review, enables HSAG reviewers to become familiar with the CMO's structure, staffing, operations, and unique processes. Based on the desk review, HSAG reviewers will draft interview questions to be addressed by the CMO's staff members during the on-site review.

Posting the Agenda and File Review Lists

Approximately one week prior to the on-site review, HSAG will post the agenda and schedule the review for one to two consecutive business days depending on the number of standards and file reviews included in the compliance activities for that year. The agenda lists the proposed date and time for interviews with the CMO's staff members. HSAG always allows an opportunity to rearrange the interview and file review times to accommodate the needs of the CMO's staff members in addition to allowing changes to be made to the agenda while on-site.

Approximately one week prior to the on-site compliance review, HSAG will post to the FTP site the list of the files to be audited during the on-site visit. After HSAG notifies the CMO the lists have been posted to the FTP site, the CMO will compile the documents needed for the file reviews and have the information available on the first day of the on-site review.

STEP 6: COMPLETING ON-SITE REVIEW ACTIVITIES

Opening Conference and Staff Interviews

The first activity that occurs during the on-site review is the opening conference. HSAG staff members will introduce themselves and explain their roles in the on-site compliance review activities. The CMO staff members will also introduce themselves and may share information about their operations. HSAG staff members will review the proposed agenda and on-site activities with the CMO's staff members to determine if any adjustments are needed to the agenda or the proposed interview times.

Following the opening conference, the on-site interviews will begin. HSAG will meet with the key CMO staff members who perform activities associated with each standard to determine the processes for operationalizing the CMO's policies and procedures. HSAG reviewers will also ask questions to clarify the information submitted with the pre-on-site documents. HSAG will conduct interviews with the CMO staff members to:

- ***Gain a clear and concise understanding of the CMO's compliance with the regulatory requirements.***
- ***Answer questions from the CMO staff members about the review standards.***
- ***Receive clarification concerning any pending questions generated after reviewing the pre-on-site documents.***
- ***Compare the information gained from reviewing the pre-on-site documents to information gained during the interviews.***
- ***Provide the opportunity for HSAG reviewers to request additional relevant documents that may not have been included in the pre-on-site documentation.***
- ***Encourage the CMO's staff members to share any innovative projects undertaken to improve processes or enhance reporting capabilities.***

Collecting Other Accessory Information

HSAG's reviewers will continually evaluate additional documentation provided during the on-site reviews. Additional documentation may be in the form of committee minutes, reports, documents, or records that were not submitted prior to the audit. HSAG reviewers will log each document submitted by the CMO during the on-site review so it may be referenced later.

When conducting the file reviews, HSAG will evaluate the files with a CMO staff member present so the HSAG reviewer may ask the staff member questions and clarify questionable processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the CMO staff member the opportunity to locate the missing information. An element is marked as deficient only if the staff member cannot locate the information needed to satisfy the element on the review tool.

Closing Conference and Exit Interviews

The final activity during the on-site review is the closing conference and the exit interviews. At the end of the on-site visit, HSAG will conduct a closing summation with the CMO staff members to discuss HSAG's comprehension of information obtained during the compliance review process. The CMO's staff members may also answer additional questions and present supplementary documentation to clarify an area of concern noted by HSAG.

During the closing conference, HSAG will provide information about the next steps in the compliance review process. Next steps involve analyzing the information obtained during the on-site review and compiling the findings from all the HSAG on-site reviewers. During the closing conference, HSAG will communicate the approximate timeline for submitting the draft report to the DHCFP and the CMO, as well as the process for submitting a remediation or corrective action plan, should one be required.

STEP 7: ANALYZING AND COMPILING FINDINGS

HSAG will analyze the information the CMO submits for the desk review, the responses received during the interviews, the findings from the file reviews, and the results of the review of additional documentation presented during the on-site review to determine compliance with each standard and element listed in the compliance review tools. HSAG must be able to validate (via evidence found in the CMO's documents, record reviews, interviews, and various other outcome results) the CMO

developed operational policies and processes, followed those processes, and complied with federal regulations and the State's standards and requirements.

After the HSAG reviewers finish documenting the findings, they will assign the scores for the compliance review. HSAG analyzes each element within a standard separately and assigns a specific rating for each element. HSAG tallies the ratings for the elements listed in a standard to produce an overall score for each standard. The review team leaders ensure the findings support the scores assigned to each standard. HSAG is diligent in the quality control processes it uses to ensure reviewers are accurate and consistent when documenting the results of the on-site review activities. Team members discuss their findings to ensure consistency in documenting and evaluating policies and processes, and determining the scores across all standards.

For the Nevada compliance reviews, HSAG will use compliance ratings of Met, Partially Met, or Not Met. This system is supported by the protocols established by CMS in the Assessment of Compliance with Medicaid Managed Care Regulations, Version 2.0, dated September 1, 2012, and used in many of the states in which HSAG conducts EQR compliance reviews. If a requirement is not applicable to the CMO for the period covered by HSAG's review, HSAG will use a Not Applicable (NA) scoring designation. During the creation of the compliance tools, HSAG will assign point values to assist in creating a percentage-of-compliance score that can be used to quantify the CMO's performance, provide trending information, and illustrate improvement over time when follow-up reviews are performed. HSAG will produce a compliance report and will also present the compliance scores in the EQR technical report, as required by 42 CFR §438.364.

STEP 8: REPORTING RESULTS

Once results from the on-site review are compiled and the level of compliance with each review is determined, HSAG will create a comprehensive compliance report that includes a copy of the completed compliance tools used for the review. The compliance tools contain the findings for each element reviewed, as well as a description of the areas that are less than fully compliant that may require remediation or corrective action. HSAG will also include a template the CMO will use to document the proposed corrective action plans for each requirement that did not receive a Met rating.

Prior to releasing the draft compliance review report, the HSAG team lead will send the draft report to HSAG's validation team and professional editors who provide a final check for clarity and accuracy. HSAG ensures the reports are well-written, accurate, and complete. After the editing and final review by the on-site review team, HSAG will send the report to DHCFP staff members to give them the opportunity to review the report and provide feedback to HSAG. After HSAG receives feedback, HSAG will send the report with the corrective action plan template to the CMO to provide a response to each area that did not receive a Met rating. While the timeline for the CMO response to the corrective action plan template may vary, the DHCFP and HSAG usually allow a vendor two weeks to submit the corrective action plan using the template provided in the report. While HSAG facilitates the process for reviewing and accepting the corrective action plans submitted by vendors, the DHCFP maintains ultimate authority for approving vendor corrective action plans.

HSAG will ensure the compliance report is 508-compliant and will provide the reports to the DHCFP and the CMO in hard copy and electronic format. HSAG understands the State retains ownership of all contract deliverables and has the unlimited rights to use, disclose, or duplicate all deliverables produced by HSAG. To review a copy of the most recent completed compliance review report of the CMO, please refer to Section VIII – Other Informational Material, Attachment E – Compliance Review Report of CMO.

Validation of Performance Measures

HSAG is prepared to validate performance measures for the DHCFP's CMO vendor using CMS protocol for validating performance measures. HSAG has extensive experience using the CMS Validating Performance Measures Protocol to determine the extent to which performance measure rates were calculated following the technical specifications and verifying the accuracy and reliability of the methods that were used to collect the performance measure data. HSAG has conducted performance measure validation of CMO non-P4P performance measures since 2015. HSAG understands the DHCFP is preparing to phase-out the Health Care Guidance Program (HCGP), which affects the CMO. HSAG is well equipped to work with the DHCFP to determine performance measure validation activities that will be needed for a replacement vendor, should one be selected.

HSAG's proposed approach to conduct performance measure validation for a future CMO vendor, should one be selected, are described in the following paragraphs.

Description of Validation Activities

Pre-audit Strategy

HSAG will conduct the performance measure validation (PMV) activities using aspects of the validation activities that are outlined in the CMS performance measure validation protocol. HSAG will validate up to five performance measures selected by the DHCFP for the DHCFP CMO vendor. HSAG will assemble a validation team based on the full complement of skills required for validating the specific performance measures and conducting the information system review. The team will be composed of a lead auditor and several team members. HSAG will provide technical assistance to the DHCFP's CMO vendor's staff throughout the audit process.

HSAG will prepare and send a documentation request letter to the CMO vendor, which outlines the steps in the PMV process. The document request letter will include a request for source code for each performance measure, a completed ISCAT, any additional supporting documentation necessary to complete the audit, and a timetable for completion and instructions for submission. The ISCAT will be customized to collect information regarding the care coordination vendor's processes that are consistent with the Nevada special terms and conditions (STCs).

Upon receiving the completed ISCAT and requested supporting documents, HSAG will conduct a desk review of all the materials and note any issues or items that required further follow-up. An agenda associated with the on-site visit will be sent to the CMO vendor. The agenda will describe the on-site activities and indicate the type of staff the CMO vendor would need to make available for interviews for each session. In addition, staff members from HSAG, the DHCFP, and the CMO vendor will participate in a kick-off conference call to discuss issues identified from the ISCAT desk review, and to discuss the on-site visit agenda, logistics and expectations, as well as important deadlines. HSAG will also request that preliminary rates be provided by the CMO vendor before the on-site audit.

Prior to the on-site visit, HSAG also will conduct an extensive review of the CMO vendor's source code used to calculate the five selected measures. HSAG's source code reviewers will perform a line-by-line review of the source code to assess whether the codes were developed according to the measure specifications detailed in the CMO vendor's contract with the DHCFP. Findings of the source code review will be provided to the CMO vendor, and all issues will need to be resolved prior to the on-site audit. Following approval of the source code, the preliminary rates will be calculated by the CMO vendor and be provided to HSAG. This strategy will allow HSAG to review numerators, denominators, and rates to tailor the on-site review around any potential issues identified with the calculations.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG will conduct an analysis of these data:

- ***Information Systems Capabilities Assessment Tool (ISCAT): The CMO vendor will be required to submit an ISCAT prior to the on-site audit. The ISCAT will be customized to collect information regarding the data necessary for reporting the performance measures. HSAG will respond to ISCAT-related questions received directly from the CMO vendor during the pre-on-site phase.***
- ***Source code (programming language) for performance measures: All performance measures source code under the scope of this review will be reviewed and approved by HSAG source code reviewers.***
- ***Prior years' validation of performance measure reports: When data becomes available, HSAG will review previous years' reports to assess for appropriate populations and rate reasonability.***

On-Site Activities

HSAG will conduct an on-site visit with the CMO vendor. HSAG auditors will collect information from the CMO vendor's staff members using several methods, which include interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities will include the following:

- ***Opening session: The opening session will include introductions of the validation team and key CMO vendor staff members involved in the performance measure validation activities. Discussion during the session will address the review purpose, the required documentation, basic meeting logistics, and queries to be performed.***
- ***Evaluation of system compliance: The evaluation will include a review of the information systems, focusing on the receipt and handling of enrollment and disenrollment data. Additionally, HSAG will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT, HSAG will conduct interviews with key CMO vendor staff members who are familiar with processing, monitoring, and calculating performance measures. HSAG will use interviews to confirm findings from the documentation review and to clarify outstanding issues.***
- ***Overview of data integration and control procedures: The overview will include discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG will perform primary source verification queries and a walk-through of source code files to further validate the output files. HSAG also will review any supporting documentation provided for data integration.***
- ***Closing conference: The closing conference will summarize preliminary findings based on the review of the ISCAT and the on-site visit, and review the documentation requirements for any post-on-site activities.***

Post-On-Site Activities

During the on-site visit, HSAG auditors will follow-up on any outstanding issues for the CMO vendor, such as documentation explaining any rate variances of one percent or greater for measures reviewed during the performance measure validation audits or documentation explaining the different

challenges faced when calculating the CMO vendor's rates. Upon resolving all outstanding items, HSAG auditors will review the rates provided by the CMO vendor before issuing this report.

Performance Measure Validation Results

Upon receipt of the final performance measure results generated by the CMO vendor, HSAG will finalize the draft performance measure validation report for the CMO vendor. The draft performance measure validation report will be submitted to the CMO vendor and to the DHCFP for review. HSAG will incorporate feedback received from the DHCFP and the CMO vendor, as appropriate and finalize the performance measure validation report.

2.1.5.3 The awarded vendor may be asked to assist with the development and/or implementation of the Medicaid managed care quality rating system within 3 years of the date of the final notice in the FEDERAL REGISTER by:

A. Adopting the Quality Rating System developed by CMS, in consultation with States and other stakeholders and after providing public notice and opportunity to comment, will identify performance measures and a methodology for a Medicaid managed care quality rating system that aligns with the summary indicators of the qualified health plan quality rating system; or

B. Adopting an alternative Medicaid managed care rating system approved by CMS that utilizes different performance measures or applies a different methodology as long as the ratings generated by the alternative rating system yield information regarding the MCOs, and PAHP performance is substantially comparable to that yielded by the system developed by CMS.

HSAG understands and will comply with the requirements set forth in 2.1.5.3.A through B.

DEVELOPMENT AND IMPLEMENTATION OF QUALITY RATING SYSTEM

As described in 42 CFR §438.334, each state contracting with an MCO, PIHP, or PAHP to furnish services to Medicaid members must adopt the Medicaid managed care quality rating system (QRS) developed by CMS or adopt an alternative QRS. The purpose of a QRS is to enable states to better measure and manage the quality of care furnished by managed care organizations and to assist consumers in selecting a managed care organization. For Nevada, HSAG is prepared to develop a QRS that highlights the performance of Nevada's MCOs and DBA/PAHP, per the DHCFP's requirements and specifications.

HSAG uses its knowledge and experience to develop sound analytic and methodological techniques for producing QRSs (i.e., consumer guides or report cards) for several state Medicaid agencies, including Illinois, Iowa, Michigan, Ohio, and Virginia. In addition, HSAG's Chief Data Officer served on the CMS Technical Expert Panel that provided recommendations to CMS on the methodology for the Medicaid and CHIP Managed Care QRS. HSAG will be able to leverage its knowledge and expertise to assist the DHCFP in aligning with CMS' QRS specifications or developing an alternative methodology that will meet CMS' requirements. Further, HSAG staff have extensive experience working with state Medicaid agencies to define their QRSs and present the results to key stakeholders within each state.

Once the QRS methodology is selected by the DHCFP, HSAG will work with the DHCFP to collect the appropriate data from the MCOs and the DBA/PAHP. In addition, HSAG will develop a draft QRS template for the DHCFP's review and feedback. Staff will work with the DHCFP to present the information to MCOs and the DBA/PAHP to solicit feedback and incorporate into the QRS template to ensure the format meets the standards of the DHCFP. HSAG will ensure that the QRS developed for Nevada will be inclusive of both Medicaid and Nevada Check Up data.

Identification of Performance Measures and Managed Care Quality Rating System Methodology

Once CMS releases the technical specifications for the Medicaid and CHIP (MAC) QRS, HSAG will work with the DHCFP to determine if the DHCFP will adopt CMS' QRS methodology or elect to implement an alternative methodology. As part of this process, HSAG will work with the DHCFP to seek MCO and DBA/PAHP input on the QRS methodology and performance measures. If the DHCFP elects to implement CMS' methodology, HSAG will review the measures and methodology specifications and provide recommendations to the DHCFP that align with the QRS summary indicators based on availability of data and the DHCFP's required services. HSAG will derive these recommendations based on HSAG's expertise with developing and implementing QRSs in several states. If the DHCFP elects to implement CMS' methodology, HSAG will produce the QRS using the technical specifications for the DHCFP to publish on an annual basis.

Alternative Rating System

Once CMS releases the QRS technical specifications, HSAG will work with the DHCFP to determine if an alternative QRS methodology will need to be developed. If the DHCFP elects to implement an alternative QRS methodology, HSAG will propose a methodology that has been successfully employed in several states. The alternative methodology will utilize available HEDIS data and CAHPS survey results to calculate summary scores for each MCO and the DBA/PAHP for specified quality domains. HSAG will compare each MCO's performance to the DHCFP-defined benchmarks, such as statewide averages or specified State-defined targets. Similarly, HSAG will compare DBA/PAHP performance to performance targets established by the DHCFP. The difference between an MCO's score and the established benchmark will determine the MCO ratings for individual and summary measures (e.g., above average, average, or below average). HSAG will work with the DHCFP to ensure that the rating system meets its needs and is easily interpreted by the intended audience (e.g., Medicaid and Check Up members), while truly reflecting the quality of each MCO's and the DBA/PAHP's performance. Furthermore, HSAG will work with the DHCFP to determine the most appropriate format to display the QRS results based on how the DHCFP intends to disseminate the QRS to the public domain. Once the DHCFP approves of the alternative methodology, HSAG will work with the DHCFP to receive CMS approval on the alternative methodology. HSAG will produce the QRS using the CMS-approved alternative methodology for the DHCFP to publish on an annual basis.

2.1.5.4 The awarded vendor may be asked to perform the following quality activities for a new Nevada Medicaid Aged Blind and Disabled (ABD) managed care expansion program. Tasks may include:

A. Provide consulting to DHCFP for ABD performance measures. The EQRO will identify/recommend new or revised performance measures applicable to the ABD population;
B. Conduct an Information Systems (IS) Readiness Review on selected ABD MCO Vendors; and
C. Evaluate implementation of performance measures.

HSAG understands and will comply with the requirements set forth in 2.1.5.4.A through C.

Quality Activities for Nevada ABD Managed Care Expansion Program

HSAG has a wealth of knowledge and experience in conducting EQR activities for Aged Blind and Disabled (ABD) programs in other states. Currently, eight of the states where HSAG is an EQRO enroll ABD populations in managed care plans. Similar to its expertise and preparedness to perform other

EQR services for the DHCFP, HSAG's experienced, skilled, and knowledgeable staff are prepared to provide consultation, education, training, and technical assistance to the DHCFP in the areas of:

- ***Identifying and/or developing performance measures that are appropriate for the ABD population.***
- ***Conducting information systems (IS) and operational readiness reviews of selected ABD MCO vendors.***
- ***Evaluating the implementation of performance measures by ABD MCOs, and ensuring the State's quality strategy is updated to include performance measures, performance improvement projects, contract compliance, network validation, and associated quality improvement activities geared toward the ABD population.***

As an EQRO, HSAG believes a collaborative and educational approach to EQR activities for new ABD MCOs is imperative to achieving positive outcomes. HSAG's approach to providing quality review services to states and their newly contracted ABD MCOs is flexible and responsive to the unique needs, culture, and EQRO contract requirements of a state. Drawing from its extensive pool of subject matter experts, HSAG will undertake activities requested by the DHCFP that enable the Division to fully implement and realize its strategic and quality improvement goals defined for the program.

Consultation to DHCFP for ABD Performance Measures

HSAG understands that the DHCFP may request consultation for the identification or recommendation of performance measures for the ABD managed care expansion program. HSAG has extensive experience in developing and conducting performance measure validation for managed care and long-term care systems. HSAG staff have worked at state Medicaid programs and led the identification, development, implementation and reporting of measures focused on the ABD population and the developmentally disabled population. While employed by the state Medicaid program, these staff worked closely with CMS and their contractors to develop and test MLTSS and long-term care (LTC) performance measures and a CAHPS survey focused on the ABD and the developmentally disabled populations.

HSAG also has the unique experience of developing and calculating measures for national use that conform to the goals of the national quality strategy. HSAG contracted to assist CMS with managing numerous measures across all healthcare settings. HSAG provided CMS with a set of management processes and decision criteria to guide the development, implementation, and maintenance of quality measures. HSAG will capitalize on this experience to identify, review and recommend performance measures to the DHCFP for the ABD population.

Through its EQRO contract with the State of Ohio, HSAG assesses the Medicaid managed care plans' (MCPs') performance using access, clinical, and informational performance measures for ABD and covered families and children (CFC) populations. HSAG is responsible for working with Ohio to update measure specifications, calculate clinical and access performance measure rates, and report the findings for each MCP. HSAG also produces a consumer information guide annually reflecting Ohio MCPs' performance scores.

As part of its approach to identify and recommend new or revised performance measures HSAG has identified several key steps it will take to assure that the performance measures recommended by HSAG are appropriate for use with the ABD population and are meaningful for the DHCFP. Those steps include:

- ***Step 1: Population Scan—HSAG will review the population to be served in the ABD managed care program, which includes a review of the most prevalent conditions and diagnoses. HSAG will also review the utilization of services by the population over the past several years.***
- ***Step 2: Confirm Strategic Objectives—HSAG will confirm the strategic quality objectives that are most important to the DHCFP for the ABD managed care program.***
- ***Step 3: Identify Use of New or Existing Performance Measures—HSAG will identify a set of nationally recognized and tested performance measures that can be used for the DHCFP ABD managed care program. HSAG will ensure that all measures have clear, detailed specifications and that sufficient data sources are available to support the requisite measure calculations. If modifications are needed, HSAG will modify the measures as appropriate.***
- ***Step 4: Obtaining Meaningful Results—HSAG will verify that the performance measures will produce meaningful and robust results for the DHCFP's clinical and non-clinical areas of focus, and that these results meet the requirements for evaluating MCO performance. HSAG will confirm these measures support the DHCFP mandates, objectives, and performance measure requirements.***
- ***Step 5: Update Measures—As part of the annual quality strategy evaluation, HSAG will work with the DHCFP to annually evaluate the measures to determine if the measures are: still current, meet the strategic quality objectives for the program, or need to be expanded to include new measures that evaluate additional conditions or health needs of the population served in the program. If any adjustments are needed to the list of measures used for the ABD managed care program, HSAG will recommend modifications to existing measures or new measures that will better serve the needs of the program and meet the DHCFP's quality objectives.***

Information Systems Readiness Review on ABD MCO Vendors

As the nation's largest EQRO, HSAG has designed and conducted Medicaid and dual Medicare/Medicaid readiness reviews in more than 15 states for over 100 health plans. HSAG's comprehensive approach to readiness reviews result in more than just an arbitrary determination of health plan readiness. HSAG assesses each MCO's preparations and ability to comply with federal and state contract standards, and most importantly, provides the state and the MCOs with technical assistance to effectively remediate critical gaps in knowledge and operational and systems capabilities. In 2017, HSAG successfully conducted the information systems (IS) and operational readiness reviews for the two new MCOs in Nevada that were awarded contracts in response to RFP 3260 and for the dental benefits administrator (DBA/PAHP) that was awarded a contract in response to RFP 3425.

In accordance with 42 CFR §438.66(d)(1)(ii-iii), the DHCFP must assess the readiness of a new MCO that has not previously contracted with the state or of an existing MCO that will provide covered benefits to new eligibility groups. Because the MCOs currently operating in the State of Nevada administer covered benefits to the TANF/CHAP and CHIP populations, a new or existing MCO selected to provide services to the ABD population would require a readiness review. Further, 42 CFR §438.66(d)(3) includes the provision that readiness reviews must include both a desk review of documents and on-site reviews that include interviews of the MCO staff and leaders of the key operational areas. Lastly, 42 CFR §438.66(d)(4) requires that readiness reviews assess the ability and

capacity of the MCO to perform satisfactorily in four key areas–operations/administration, service delivery, financial management, and systems management.

HSAG's approach to conducting readiness reviews of a new MCO's information systems and operational structure has been proven effective regardless of the vendor being reviewed. The process for organizing, planning, developing data collection tools, collecting data, completing the desk and on-site portions of the readiness review, aggregating findings, and reporting results varies only slightly when conducting a readiness review of a new MCO or an existing MCO, who's population or service area expanded. The description of HSAG's approach to conducting IS and operational readiness reviews that follows is similar to the one described in HSAG's response to Section 2.1.5.5, with slight modifications detailed in each.

Approach to IS and Operational Readiness Reviews

The purpose of the operational readiness review is to assess that each MCO has the structural and operational capacity to perform the Medicaid managed care functions described in the MCO's contract with the DHCFP and ensure appropriate and timely access to quality healthcare services for Medicaid enrollees. The readiness reviews HSAG performs consist of two components: (1) operational readiness review, and (2) information systems (IS) readiness review. The purpose of the IS readiness review is to evaluate each MCO's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases. While two distinct areas of MCO operations are evaluated by the operational and IS readiness reviews, the process for acquiring MCO-specific data and determining the readiness of the MCO is the same.

To complete a comprehensive operational and IS readiness review of future vendors, HSAG organizes the activities into 10 steps, which include:

1. ***Planning for the readiness review***
2. ***Creating a crosswalk of contract areas to federal requirements***
3. ***Creating data collection tools***
4. ***Training reviewers***
5. ***Collecting data***
6. ***Completing pre-on-site activities***
7. ***Completing on-site reviews***
8. ***Analyzing and compiling findings***
9. ***Reporting results***
10. ***Facilitating MCO remediation activities***

HSAG expands on each of these steps in the description that follows.

Step 1: Planning for Readiness Review Activities

HSAG understands that planning is a vital component in conducting an efficient and effective readiness review. The Nevada EQR contract manager collaborates with the DHCFP to customize the approach to the readiness review process to ensure the review meets federal requirements, contract requirements, and the DHCFP's requests and preferences. HSAG is prepared to provide technical assistance and ongoing communication to each MCO vendor and the DHCFP regarding the process, timelines, and expectations to ensure the readiness review process is methodical, well-organized, efficient, and effective.

Once the DHCFP requests that HSAG conduct a readiness review of a selected ABD MCO vendor, HSAG will propose a work plan for the readiness review that includes the activities and associated timelines necessary to complete the review. HSAG typically initiates readiness review activities approximately five months before the MCO contract start date. HSAG will determine the dates of the on-site review in collaboration with the DHCFP and vendor being reviewed. Once HSAG confirms the date with the DHCFP, HSAG will notify the HSAG readiness review team and the vendor so that all may prepare for the upcoming reviews.

Step 2: Creating a Crosswalk to Federal Requirements

The operational readiness review includes an assessment of 15 standards based on the requirements of Nevada MCOs' contracts. These standards are cross-walked to the key areas noted in 42 CFR §438.66(d)(4) and are presented in the table that follows. The IS readiness review includes an assessment of two standards based on the requirements of the MCO contract and are cross-walked to key areas noted in noted in 42 CFR §438.66(d)(4). The IS readiness review standards are also included in Table 2.1.5.4-1 that follows.

Table 2.1.5.4-1: Crosswalk of Nevada Readiness Review Standards to Federal Readiness Review Areas

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)13
Standard I: Internal Quality Assurance Program	Quality improvement
Standard II: Credentialing and Recredentialing	Provider network management
Standard III: Member Rights and Responsibilities	Enrollee and provider communications
Standard IV: Member Information	Member services and outreach
Standard V: Availability and Accessibility of Services	Provider network management
Standard VI: Continuity and Coordination of Care	Case management/care coordination/service planning
Standard VII: Grievance and Appeals	Grievance and appeals
Standard VIII: Subcontracts and Delegation	Delegation and oversight of MCO responsibilities
Standard IX: Cultural Competency Program	Provider network management
Standard X: Coverage and Authorization of Services	Utilization review
Standard XI: Provider Dispute and Complaint Resolution	Grievance and appeals
Standard XII: Confidentiality and Recordkeeping	Delegation and oversight of MCO responsibilities
Standard XIII: Provider Information	Provider network management
Standard XIV: Enrollment and Disenrollment	Member services and outreach
Standard XV: Program Integrity	Program integrity/compliance
Information System (IS) Readiness Review Standards	**Federal Readiness Review Areas 42 CFR §438.66(d)(4)**
IS Review Standard I: Enrollment Systems	Encounter data /enrollment information management Claims management
IS Review Standard II: Claims and Encounter Systems	

[13] *An assessment of the MCO's financial reporting and monitoring and financial solvency are performed by the DHCFP.*

Step 3: Creating Readiness Review Tools

HSAG understands the importance of developing complete and accurate readiness review tools that support comprehensive and objective evaluations of the vendor. HSAG creates the readiness review tools from the State-specific requirements found in the vendor's contract with the DHCFP and the associated federal requirements found in 42 Code of Federal Regulations (CFR) §438. Every readiness review involves a review of documents that include policies, procedures, and process information. HSAG's readiness review tools, tracking forms, training and interview guides, site visit agendas, file/record review checklists, on-site document review lists, pre-assessment desk review information lists, and other supportive working papers are tested, used, and improved by performing readiness review activities for the DHCFP.

For the IS readiness review, HSAG creates the IS Readiness Desk Review Tool and IS Claims and Encounters Systems Testing tools. These tools are used to document the findings from the remote systems claims testing and encounter file validation conducted with the MCO as part of the IS readiness review. The test scenarios will include a range of professional, institutional, and pharmacy claims designed to encompass Nevada ADB managed care benefits and billing requirements. The MCO will be provided fictitious recipients, providers, and claim files to be loaded into the MCO's test systems to review with HSAG via WebEx on the day of systems testing. One week after the systems testing, the MCO will be required to submit the test claim encounter files in accordance with the DHCFP's encounter submission file formats. The IS Claims and Encounters Systems Testing tools provide a record of HSAG's findings regarding the MCO's ability to process claims and submit encounters according to the scenarios.

The readiness review also includes file reviews of initial credentialed providers to verify the vendor puts into practice what is written in its contract, as well as its policies. HSAG also uses checklists to review the vendor's contractual compliance for certain documents, such as the member handbook, provider manual, members' rights, and medical record standards related to confidentiality and record keeping.

After HSAG drafts the readiness review tools, HSAG's contract manager will submit the tools to the DHCFP for review. The documents sent to the DHCFP may include the readiness review evaluation tools, file review tools, checklists, and copies of the correspondence to be sent to the vendors in preparation for the on-site readiness review and claims processing demonstration.

Step 4: Training the HSAG Readiness Review Team

HSAG's operational readiness review team is led by HSAG's contract manager, Gretchen Thompson, who has conducted the compliance and readiness reviews of Nevada managed care vendors since 2009. The IS readiness review is led by Holly Dolgaard, who has performed IS readiness reviews of MCOs for over five years. Ms. Thompson, Ms. Dolgaard, and the readiness review team members have extensive knowledge of current best practices in the industry, Medicaid managed care programs and related regulations, as well as Nevada-specific practice guidelines in the areas of access, structure and operations, and measurement and improvement. The team chosen for the Nevada readiness reviews will include HSAG staff members who have extensive experience in conducting compliance and readiness review activities for MCOs in Nevada, as well as other states.

HSAG's contract manager conducts a training session for the readiness review team to provide them with Nevada-specific managed care program nuances and contract requirements. This team training helps to standardize the process for documenting information garnered from the desk review and interviews with vendor staff members. Items covered during the training sessions include:

- ***CMS Medicaid managed care requirements included in the readiness review.***
- ***State-specific requirements included in the readiness review.***
- ***Requirements for any checklists or file reviews included in the readiness review.***
- ***Structure and operation of the Nevada ABD managed care program.***
- ***Instructions concerning the completion of the readiness review tools and reports.***
- ***Timelines associated with the readiness review.***

Step 5: Collecting Readiness Review Data from the Vendors

Approximately eight weeks prior to the on-site review, HSAG will send the readiness review documents to the vendors. The information includes the DHCFP-approved readiness review tools and detailed instructions for completing the documents that must be submitted to HSAG for the pre-on-site desk review. HSAG also provides information about accessing HSAG's FTP site. The FTP site provides a secure location to upload the review tool and the desk review documents. HSAG's cover letter that describes the readiness review instructs the vendor to upload all documentation to HSAG's FTP site by a specified date, usually four weeks prior to the on-site review. Once the vendor uploads the information to the HSAG FTP site, HSAG reviewers retrieve files from the FTP site to begin the pre-on-site document review.

HSAG also conducts credentialing file reviews during the on-site readiness review. In the instructions to the vendor to request documentation, HSAG includes requirements to post data files to HSAG's FTP site that lists activities that occurred within a specific period. For example, for credentialing, the vendor must provide a list of providers who were credentialed before a specified date. From the list, HSAG selects the cases to be reviewed during the on-site review to ensure the MCO appropriately credentials providers who will serve ABD members enrolled with the MCO.

Step 6: Completing Pre-On-Site Review Activities

After HSAG receives the documents from the vendor, the team leader and on-site reviewers begin activities to assess the MCO's readiness to perform the federal and State requirements, as described in the subsections that follow:

Technical Assistance Teleconference

Within two weeks of HSAG sending the readiness review tools and instructions to vendors, the HSAG readiness review team hosts a webinar with vendors to introduce the various documents that were sent each vendor and to reiterate the process for completing the vendor questionnaire, readiness review evaluation tool, and for uploading documents to the HSAG FTP site. It is during this webinar that vendor staff members may:

- ***Ask questions and seek clarification about the readiness review tools, supporting documentation, the process for uploading information to the HSAG FTP site.***
- ***Clarify the timelines and logistics associated with the readiness review.***
- ***Review claims and encounter systems testing objectives and seek guidance on preparing for systems testing performed by HSAG.***

In HSAG's experience, this simple 60- to 90-minute webinar enables vendor staff to better prepare for the readiness review, thus ensuring a more productive experience for the vendors, HSAG, and the DHCFP.

Pre-On-Site Document Review

Approximately four weeks prior to the on-site review, the HSAG team leader and on-site reviewers begin the pre-on-site or desk review of documents submitted by each vendor. The pre-on-site review, or desk review, enables HSAG reviewers to become familiar with each vendor's structure, staffing, operations, claims and encounter processing systems, and unique processes. Based on the desk review, HSAG reviewers draft interview questions to be addressed by vendor staff members during the on-site review.

Posting the Agendas and File Review List

Approximately one week prior to the on-site review, HSAG posts the agenda and schedules the operational and IS readiness reviews. The agenda lists the proposed date and time for interviews with the vendor's staff members. HSAG always allows the vendor the opportunity to rearrange the interview and file review times to accommodate the needs of its staff members. HSAG also posts the claims testing scenarios the vendor must use to demonstrate its claims adjudication and encounter processing systems.

Approximately one week prior to the review, HSAG posts to the FTP site the list of the files to be audited during the operational on-site visit. After HSAG notifies the vendor that the lists are posted to the FTP site, the vendor compiles the documents needed for the file reviews to have the information available on the first day of the on-site review.

STEP 7: COMPLETING READINESS REVIEW ACTIVITIES

Opening Conference and Staff Interviews

The first activity that occurs during the on-site review is the opening conference. HSAG staff members introduce themselves and explain their roles for the readiness review activities. The vendor staff members also introduce themselves and may share information about their plan operations. HSAG staff members review the proposed agenda with the vendor's staff members to determine if any adjustments are needed to the agenda or the proposed interview times.

Following the opening conference, the readiness review interviews begin. HSAG meets with the key vendor staff members who perform activities associated with each standard to determine the processes for operationalizing the vendor's policies and procedures. HSAG reviewers also ask questions to clarify the information submitted with the pre-on-site documents. HSAG conducts interviews with the vendor staff members to:

- ***Gain a clear and concise understanding of the vendor's ability to meet the regulatory requirements.***
- ***Answer questions from the vendor staff members about the review standards.***
- ***Receive clarification concerning any policies, procedures, and processes presented by the MCO.***
- ***Compare the information gained from reviewing the pre-on-site documents to information gained during the interviews.***
- ***Provide the opportunity for HSAG reviewers to request additional relevant documents that may not have been included in the pre-on-site documentation.***
- ***Process test claims in a live claims adjudication environment using the claims processing scenarios provided by HSAG.***

- ***Review claims monitoring and audit controls.***
- ***Review the MCO's encounter data processes and systems.***

Collecting Other Accessory Information

HSAG's reviewers continually evaluate additional documentation provided during the on-site reviews. Additional documentation may be in the form of committee minutes, reports, documents, or records that were not submitted prior to the audit. HSAG reviewers log each document submitted by the vendor during the on-site review so it may be referenced later.

When conducting the file review, HSAG evaluates the files with a vendor staff member present so the HSAG reviewer may ask the staff member questions and clarify questionable processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the vendor staff member the opportunity to locate the missing information. An element is marked as deficient only if the staff member cannot locate the information needed to satisfy the element on the review tool.

Closing Conference and Exit Interviews

The final activity during the readiness review is the closing conference and the exit interviews. At the end of the readiness review, HSAG conducts a closing summation with the vendor staff to discuss HSAG's comprehension of information obtained during the readiness review process. Vendor staff members may also answer additional questions and present supplementary documentation to clarify an area of concern noted by HSAG.

During the closing conference, HSAG provides information about the next steps in the readiness review process. Next steps involve analyzing the information obtained during the on-site review and compiling the findings from all the HSAG on-site reviewers. During the closing conference, HSAG communicates the approximate timeline for submitting the draft report to the DHCFP and the vendor, as well as the process for submitting a remediation or corrective action plan, should one be required.

STEP 8: ANALYZING AND COMPILING FINDINGS

From a review of documents, observations, and interviews with key staff during the readiness review, the HSAG reviewer assigns a score for each element and an aggregate score for each standard for the Operational Readiness Review Evaluation tool and the IS Readiness Desk Review tool. Certain elements are considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, contracting with providers, and capturing enrollment and service information from the DHCFP's Management Information System (MIS) to process claims. Each element was given a score of Complete, Incomplete, or Incomplete—Critical.

HSAG's scoring included the following:

- ***Complete indicates full compliance defined as both of the following:***
  - ***All documentation listed under a regulatory provision, or component thereof, is present.***
  - ***Staff members provide responses to reviewers that are consistent with each other and with the policies and/or processes described in documentation.***
- ***Incomplete indicates noncompliance defined as either of the following:***
  - ***No documentation is present, or documentation is unclear or contains conflicting information that does not address the regulatory requirement.***
  - ***Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.***

- *For those provisions with multiple components, key components of the provision cannot be identified and any findings of Incomplete result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.*

- *Incomplete—Critical indicates noncompliance (defined above) and requires the MCO correct a deficiency prior to commencing services.*

Step 9: Reporting Results

After compiling the results from the readiness review and determining the level of completeness with each review element, HSAG creates a comprehensive readiness review report that includes a copy of the completed readiness review tools used for the review. The readiness review tools contain the findings for each element reviewed, as well as a description of the areas that are incomplete that require remediation. HSAG also includes a template the vendor uses to document the proposed remediation plans for each requirement that were found to be incomplete.

After editing and final review by the readiness review team, HSAG sends the report to the DHCFP staff members, giving them the opportunity to review the report and provide feedback to HSAG. After HSAG receives feedback, HSAG sends the report with the remediation plan template to the vendor so they may review the report and provide a response to each area that was found to be incomplete.

Step 10: Facilitating Remediation Plan Development and Approval

The remediation plan template provided in HSAG's readiness review report contains the findings and recommendation for each element found to be incomplete during the readiness review. The MCO must use the template provided in the report to submit its remediation plan to the DHCFP, which shall detail the MCO's proposed plan to remediate all elements scored Incomplete or Incomplete—Critical. The DHCFP and HSAG usually allow the vendor two weeks to submit the remediation plan using the template provided in the report. While HSAG facilitates the process of collecting the information from the MCO to support its remediation plan, the DHCFP maintains ultimate authority for critical element designation and approving remediation plans submitted in response to the readiness review report.

Once all areas found to incomplete are remedied by the vendor, HSAG produces a final report that includes the remediation plan completed by the vendor and approved by the DHCFP. This is the final step of the readiness review. HSAG provides the report to the DHCFP and the vendor in hard copy and electronic format. HSAG understands the State retains ownership of all contract deliverables and has the unlimited rights to use, disclose, or duplicate all deliverables produced by the HSAG.

Evaluation of Implementation of Performance Measures

Each year, HSAG conducts a formal evaluation of the quality strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to members was accomplished. HSAG's evaluation will include an assessment of the performance measures used in the ABD managed care program to determine if the measures were implemented properly and determine if the MCOs are conducting regular evaluation of the measures to determine where gaps in care or disparities may exist. HSAG is prepared to task the MCOs, upon the DHCFP's approval, with assignments that present each MCO's analyses of strengths and weakness related to the performance measures, which at a minimum may include:

- *Successful interventions that were used to positively impact performance measures as evidenced by an improvement of five percentage points or more.*
- *Barrier analyses performed to identify the potential causes that impacted performance measures such that they resulted in a significant decline in performance.*

HSAG will also review the measures to determine if the measures are: still current, meet the strategic quality objectives for the program, or need to be expanded to include new measures that evaluate additional conditions or health needs of the population served in the program. If any adjustments are needed to the list of measures used for the ABD managed care program, HSAG will recommend modifications to existing measures or new measures that will better serve the needs of the program and meet the DHCFP's quality objectives. HSAG is also prepared to validate ABD performance measures calculated by ABD MCOs, should the DHCFP request this activity. The approach to performance measure validation is detailed in Section 2.1.3.2 of this proposal.

2.1.5.5 The awarded vendor may be asked to perform the following quality activities for expansion of Managed Care for the TANF/CHAP and CHIP populations into the rural counties. The awarded vendor may be asked to provide consulting to DHCFP's MCOs. Tasks may include:

A. Provide consulting for expansion performance measures applicable to the TANF/CHAP and CHIP populations;
B. Conduct an Information Systems (IS) Readiness Review on selected expansion MCO Vendor(s);
C. Provide technical assistance to the MCOs on the development of performance measures; and
D. Conduct a HEDIS Compliance Audit or validate the measures using the CMS Validating Performance Measures protocol on the contracted MCOs.

HSAG understands and will comply with the requirements set forth in 2.1.5.5.A through D.

PERFORMANCE OF QUALITY ACTIVITIES FOR EXPANSION OF MANAGED CARE FOR POPULATIONS IN RURAL COUNTIES

Serving as the EQRO in 15 states, HSAG has extensive experience working with Medicaid agencies on the implementation of new managed care programs, as well as expansion of existing managed care programs. HSAG is an organization with the infrastructure necessary to undertake new quality activities as soon as requested by the DHCFP for the expansion of the TANF/CHAP and CHIP managed care program into rural counties. HSAG has worked with eight states—Nevada, Arizona, California, Colorado, Florida, Hawaii, New Hampshire, and Iowa—that implemented a managed care program for the first time. Its staff members have served as a valuable resource to states' staff members who are tasked with transitioning fee-for-service Medicaid populations to a managed care program. HSAG has highly satisfied customers resulting from its commitment to working with states through major program transitions.

As the nation's largest EQRO, HSAG offers the DHCFP a strong appreciation for the challenges and opportunities associated with expanding a Medicaid managed care program. HSAG has worked with healthcare providers, health plans, state agencies, and CMS in quality improvement efforts for over 30 years. Providing EQR-related services in 16 states and serving as the EQRO in 15 of those states uniquely positions HSAG to work with the DHCFP and its MCOs to achieve the mission of the Nevada TANF/CHAP and CHIP managed care program to "purchase and provide quality healthcare services to low-income Nevadans in the most efficient manner; promote equal access to healthcare at an affordable cost to the taxpayers of Nevada; restrain the growth of healthcare costs; and review Medicaid and other State healthcare programs to maximize potential federal revenue."

HSAG's experienced, skilled, and knowledgeable staff are prepared to provide consultation, education, training, and technical assistance to the DHCFP and the MCOs by:

- ***Providing consultation regarding additional performance measures applicable to the TANF/CHAP and CHIP populations that are appropriate for MCOs serving in rural areas.***
- ***Conducting information systems (IS) and operational readiness reviews on selected expansion MCO vendor(s).***
- ***Providing technical assistance to the MCOs on the development and implementation of performance measures.***
- ***Conducting HEDIS compliance audits for selected expansion MCO vendors.***
- ***Ensuring the quality strategy is revised to include the new geographic areas and populations included by the expansion of managed care in the rural counties.***

HSAG understands the DHCFP may request consultation for the identification or recommendation of performance measures for the TANF/CHAP and CHIP population managed care expansion into the rural counties. HSAG has extensive experience in developing and conducting performance measure validation for managed care systems and has made recommendations to the DHCFP to include or exclude performance measures, based on changes to the population or release of new performance measures that can be used in the managed care program. HSAG staff have worked at state Medicaid programs and led the identification, development, implementation and reporting of measures focused on the ABD population and the developmentally disabled population. HSAG staff have also worked closely with CMS and their contractors to develop and test MLTSS and LTC performance measures and a CAHPS survey focused on the ABD and the developmentally disabled populations.

HSAG has the unique experience of developing and calculating measures for national use that conform to the goals of the national quality strategy. HSAG contracted to assist CMS with managing numerous measures across all healthcare settings. HSAG provided CMS with a set of management processes and decision criteria to guide the development, implementation, and maintenance of quality measures. HSAG will capitalize on this experience to identify, review and recommend performance measures to the DHCFP for use in the managed care program that is expanded to the rural counties.

HSAG staff also participate in National Quality Forum Measure Application Partnerships as subject matter experts in measure selection and endorsement processes for the CMS Child Core Set, CMS Adult Core Set, Pulmonary and Critical Care, Post-Acute Care/Long-Term Care, and Primary Care and Chronic Illness. Through the work on these workgroups and committees, HSAG participate in the review of measures under development, newly endorsed measures, and measures that are up for review. Discussions of measures focuses on many factors, including applicability to the Medicaid population, population disparities including, gender, age, race, ethnicity and rural/urban. Other factors considered in the identification and selection of measures for endorsement include the ability to improve outcomes through intervention, whether a measure no longer achieves statistically significant improvement, as well as the level of effort or a cost/benefit consideration at the state, MCO, and provider level.

Consultation for Expansion of Performance Measures Applicable to TANF/CHAP and CHIP Populations

HSAG understands that, should the DHCFP decide to expand managed care to the rural counties, the Medicaid and Nevada Check Up population served will be similar to the population served in the urban counties, with the most significant difference between the two being geography and accessibility to service providers. HSAG will work with the DHCFP to examine the current set of performance measures that are used in the existing managed care program to determine the appropriateness of their use for a rural county expansion population. While the performance measures may be applicable and appropriate for a rural population, the performance targets, established as part of the quality strategy, may not be appropriate. For any performance measures selected for rural county managed care expansion, HSAG will work with the DHCFP to establish performance targets that are appropriate for the program.

As part of its approach to identify and recommend new or revised performance measures HSAG has identified several key steps it will take to assure that the performance measures recommended by HSAG are appropriate for use with the rural county expansion population and are meaningful for the DHCFP. Those steps include:

- ***Step 1: Population Scan—HSAG will review the population to be served in the rural county managed care program, which includes a review of the most prevalent conditions and diagnoses. HSAG will also review the utilization of services by the population over the past several years.***
- ***Step 2: Confirm Strategic Objectives—HSAG will confirm the strategic quality objectives that are most important to the DHCFP for the rural county expansion program, if they are different from the existing managed care program.***
- ***Step 3: Identify Use of New or Existing Performance Measures—HSAG will evaluate the current set of HEDIS measures current required of the existing managed care program and identify additional measures that may be more appropriate for the rural county expansion population if there are major differences in the epidemiological make-up of the population. HSAG will ensure that all measures have clear, detailed specifications and that sufficient data sources are available to support the requisite measure calculations. If modifications are needed, HSAG will modify the measures as appropriate.***
- ***Step 4: Obtaining Meaningful Results—HSAG will verify that the performance measures will produce meaningful and robust results for the DHCFP's clinical and non-clinical areas of focus, and that these results meet the requirements for evaluating MCO performance. HSAG will confirm these measures support the DHCFP mandates, objectives, and performance measure requirements.***
- ***Step 5: Update Measures—As part of the annual quality strategy evaluation, HSAG will work with the DHCFP to annually evaluate the measures to determine if the measures are: still current, meet the strategic quality objectives for the rural county expansion program, or need to be expanded to include new measures that evaluate additional conditions or health needs of the population served in the rural county expansion program. If any adjustments are needed to the list of measures used for the program, HSAG will recommend modifications to existing measures or new measures that will better serve the needs of the population served in the rural county expansion program and meet the DHCFP's quality objectives.***

Information Systems Readiness Review on Selected Expansion MCO Vendors

As the nation's largest EQRO, HSAG has designed and conducted Medicaid and dual Medicare/Medicaid readiness reviews in more than 15 states for over 100 health plans. HSAG's comprehensive approach to readiness reviews result in more than just an arbitrary determination of health plan readiness. HSAG assesses each MCO's preparations and ability to comply with federal and state contract standards, and most importantly, provides the state and the MCOs with technical assistance to effectively remediate critical gaps in knowledge and operational and systems capabilities. In 2017, HSAG successfully conducted the information systems (IS) and operational readiness reviews for the two new MCOs in Nevada that were awarded contracts in response to RFP 3260 and for the dental benefits administrator (DBA/PAHP) that was awarded a contract in response to RFP 3425.

In accordance with 42 CFR §438.66(d)(1)(ii-iii), the DHCFP must assess the readiness of a new MCO that has not previously contracted with the state or of an existing MCO that will provide covered benefits to new eligibility groups. Because the MCOs currently operating in the State of Nevada administer covered benefits to the TANF/CHAP and CHIP populations, a new MCO selected to provide services to the expansion populations in the rural counties would require a readiness review, while a readiness review for an existing MCO selected to provide services in the rural counties would be optional. Further, 42 CFR §438.66(d)(3) includes the provision that readiness reviews must include both a desk review of documents and on-site reviews that include interviews of the MCO staff and leaders of the key operational areas. Lastly, 42 CFR §438.66(d)(4) requires that readiness reviews assess the ability and capacity of the MCO to perform satisfactorily in four key areas—operations/administration, service delivery, financial management, and systems management.

HSAG's approach to conducting readiness reviews of a new MCO's information systems and operational structure has been proven effective regardless of the vendor being reviewed. The process for organizing, planning, developing data collection tools, collecting data, completing the desk and on-site portions of the readiness review, aggregating findings, and reporting results varies only slightly when conducting a readiness review of a new MCO or an existing MCO, who's population or territory expanded. The description of HSAG's approach to conducting IS and operational readiness reviews that follows is similar to the one described in Section 2.1.5.4.B of this proposal with slight modifications detailed in each.

Approach to IS and Operational Readiness Reviews

The purpose of the operational readiness review is to assess that each MCO has the structural and operational capacity to perform the Medicaid managed care functions described in the MCO's contract with the DHCFP and ensure appropriate and timely access to quality healthcare services for Medicaid enrollees. The readiness reviews HSAG performs consist of two components: (1) operational readiness review, and (2) information systems (IS) readiness review. The purpose of the IS readiness review is to evaluate each MCO's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases. While two distinct areas of MCO operations are evaluated by the operational and IS readiness reviews, the process for acquiring MCO-specific data and determining the readiness of the MCO is the same.

To complete a comprehensive operational and IS readiness review of future vendors, HSAG organizes the activities into 10 steps, which include:

1. ***Planning for the readiness review***
2. ***Creating a crosswalk of contract areas to federal requirements***
3. ***Creating data collection tools***
4. ***Training reviewers***
5. ***Collecting data***
6. ***Completing pre-on-site activities***
7. ***Completing on-site reviews***
8. ***Analyzing and compiling findings***
9. ***Reporting results***
10. ***Facilitating MCO remediation activities***

HSAG expands on each of these steps in the description that follows.

Step 1: Planning for Readiness Review Activities

HSAG understands that planning is a vital component in conducting an efficient and effective readiness review. Consequently, the Nevada EQR contract manager collaborates with the DHCFP to customize the approach to the readiness review process to ensure the review meets federal requirements, contract requirements, and the DHCFP's requests and preferences. HSAG is prepared to provide technical assistance and ongoing communication to each MCO vendor and the DHCFP regarding the process, timelines, and expectations to ensure the readiness review process is methodical, well-organized, efficient, and effective.

Once the DHCFP requests that HSAG conduct a readiness review of a selected expansion MCO vendor, HSAG will propose a work plan for the readiness review that includes the activities and associated timelines necessary to complete the review. HSAG typically initiates readiness review activities approximately five months before the MCO contract start date. HSAG will determine the dates of the on-site review in collaboration with the DHCFP and vendor being reviewed. Once HSAG confirms the date with the DHCFP, HSAG will notify the HSAG readiness review team and the vendor so that all may prepare for the upcoming reviews.

Step 2: Creating a Crosswalk to Federal Requirements

The operational readiness review includes an assessment of 15 standards based on the requirements of the Nevada MCOs' contracts. These standards are cross-walked to the key areas noted in 42 CFR §438.66(d)(4) and are presented in the table that follows. The IS readiness review includes an assessment of two standards based on the requirements of the MCO contract and are cross-walked to key areas noted in noted in 42 CFR §438.66(d)(4). The IS readiness review standards are also included in Table 2.1.5.5-1 on the following page.

Table 2.1.5.5-1: Crosswalk of Nevada Readiness Review Standards to Federal Readiness Review Areas

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)[14]
Standard I: Internal Quality Assurance Program	Quality improvement
Standard II: Credentialing and Recredentialing	Provider network management
Standard III: Member Rights and Responsibilities	Enrollee and provider communications
Standard IV: Member Information	Member services and outreach
Standard V: Availability and Accessibility of Services	Provider network management
Standard VI: Continuity and Coordination of Care	Case management/care coordination/service planning
Standard VII: Grievance and Appeals	Grievance and appeals
Standard VIII: Subcontracts and Delegation	Delegation and oversight of MCO responsibilities
Standard IX: Cultural Competency Program	Provider network management
Standard X: Coverage and Authorization of Services	Utilization review
Standard XI: Provider Dispute and Complaint Resolution	Grievance and appeals
Standard XII: Confidentiality and Recordkeeping	Delegation and oversight of MCO responsibilities
Standard XIII: Provider Information	Provider network management
Standard XIV: Enrollment and Disenrollment	Member services and outreach
Standard XV: Program Integrity	Program integrity/compliance
Information System (IS) Readiness Review Standards	**Federal Readiness Review Areas 42 CFR §438.66(d)(4)**
IS Review Standard I: Enrollment Systems	Encounter data /enrollment information management Claims management
IS Review Standard II: Claims and Encounter Systems	

STEP 3: CREATING READINESS REVIEW TOOLS

HSAG understands the importance of developing complete and accurate readiness review tools that support comprehensive and objective evaluations of the vendor. HSAG creates the readiness review tools from State-specific requirements found in the vendor's contract with the DHCFP and the associated federal requirements found in 42 Code of Federal Regulations (CFR) §438. Every readiness review involves a review of documents that include policies, procedures, and process information. HSAG has developed readiness review tools, tracking forms, training and interview guides, site visit agendas, file/record review checklists, on-site document review lists, pre-assessment desk review information lists, and other supportive working papers that have been used, tested, and improved by performing readiness review activities for the DHCFP.

For the IS readiness review, HSAG creates the IS Readiness Desk Review Tool and IS Claims and Encounters Systems Testing tools. These tools are used to document the findings from the remote systems claims testing and encounter file validation conducted with the MCO as part of the IS readiness review. The test scenarios will include a range of professional, institutional, and pharmacy claims designed to encompass Nevada managed care benefits and billing requirements. The MCO will

[14] *An assessment of the MCO's financial reporting and monitoring and financial solvency are performed by the DHCFP.*

be provided fictitious recipients, providers, and claim files to be loaded into the MCO's test systems to review with HSAG via WebEx on the day of systems testing. One week after the systems testing, the MCO will be required to submit the test claim encounter files in accordance with the DHCFP's encounter submission file formats. The IS Claims and Encounters Systems Testing tools provide a record of HSAG's findings regarding the MCO's ability to process claims and submit encounters according to the scenarios.

The readiness review also includes file reviews of initial credentialed providers to verify the vendor puts into practice what is written in its contract, as well as its policies. HSAG also uses checklists to review the vendor's contractual compliance for certain documents, such as the member handbook, provider manual, members' rights, and medical record standards related to confidentiality and record keeping.

After HSAG drafts the readiness review tools, HSAG's contract manager will submit the tools to the DHCFP for review. The documents sent to the DHCFP may include the readiness review evaluation tools, file review tools, checklists, and copies of the correspondence to be sent to the vendors in preparation for the on-site readiness review and claims processing demonstration.

Step 4: Training the HSAG Readiness Review Team

HSAG's operational readiness review team is led by HSAG's contract manager, Gretchen Thompson, who has been conducting the compliance and readiness reviews of Nevada managed care vendors since 2009. The IS readiness review is led by Holly Dolgaard, who has been performing IS readiness reviews of MCOs for over five years. Ms. Thompson, Ms. Dolgaard, and the readiness review team members have extensive knowledge of current best practices in the industry, Medicaid managed care programs and related regulations, as well as Nevada-specific practice guidelines in the areas of access, structure and operations, and measurement and improvement. The team chosen for the Nevada readiness reviews will include HSAG staff members who have extensive experience in conducting compliance and readiness review activities for MCOs in Nevada, as well as other states.

HSAG's contract manager conducts a training session for the readiness review team to provide them with Nevada-specific managed care program nuances and contract requirements. The team training helps to standardize the process for documenting information garnered from the desk review and interviews with vendor staff members. Items covered during the training sessions include:

- *CMS Medicaid managed care requirements included in the readiness review.*
- *State-specific requirements included in the readiness review.*
- *Requirements for any checklists or file reviews included in the readiness review.*
- *Structure and operation of the Nevada TANF/CHAP and CHIP managed care program.*
- *Instructions concerning the completion of the readiness review tools and reports.*
- *Timelines associated with the readiness review.*

Step 5: Collecting Readiness Review Data from the Vendors

Approximately eight weeks prior to the on-site review, HSAG will send the readiness review documents to the vendors. The information includes the DHCFP-approved readiness review tools and detailed instructions for completing the documents that must be submitted to HSAG for the pre-on-site desk review. HSAG also provides information about accessing HSAG's FTP site. The FTP site provides a secure location to upload the review tool and the desk review documents. HSAG's cover letter that describes the readiness review instructs the vendor to upload all documentation to HSAG's FTP site by a specified date, usually four weeks prior to the on-site review. Once the vendor uploads the

information to the HSAG FTP site, HSAG reviewers retrieve files from the FTP site to begin the pre-on-site document review.

HSAG also conducts credentialing file reviews during the on-site readiness review. In the instructions to the vendor to request documentation, HSAG includes requirements to post data files to HSAG's FTP site that lists activities that occurred within a specific period. For example, for credentialing, the vendor must provide a list of providers who were credentialed before a specified date. From the list, HSAG selects the cases to be reviewed during the on-site review to ensure the MCO appropriately credentials providers who will serve rural counties enrolled with the MCO.

STEP 6: COMPLETING PRE-ON-SITE REVIEW ACTIVITIES

After HSAG receives the documents from the vendor, the team leader and on-site reviewers begin activities to assess the MCO's readiness to perform the federal and State requirements, as described in the subsections that follow.

Technical Assistance Teleconference

Within two weeks of HSAG sending the readiness review tools and instructions to vendors, the HSAG readiness review team hosts a webinar with vendors to introduce the various documents that were sent each vendor and to reiterate the process for completing the vendor questionnaire, readiness review evaluation tool, and for uploading documents to the HSAG FTP site. It is during this webinar that vendor staff members may:

- ***Ask questions and seek clarification about the readiness review tools, supporting documentation, the process for uploading information to the HSAG FTP site.***
- ***Clarify the timelines and logistics associated with the readiness review.***
- ***Review claims and encounter systems testing objectives and seek guidance on preparing for systems testing performed by HSAG.***

HSAG has found that this simple 60-90-minute webinar enables vendor staff to better prepare for the readiness review thereby making it a more productive experience for the vendors, HSAG, and the DHCFP.

Pre-On-Site Document Review

Approximately four weeks prior to the on-site review, the HSAG team leader and on-site reviewers begin the pre-on-site or desk review of documents submitted by each vendor. The pre-on-site review, or desk review, enables HSAG reviewers to become familiar with each vendor's structure, staffing, operations, claims and encounter processing systems, and unique processes. Based on the desk review, HSAG reviewers draft interview questions to be addressed by vendor staff members during the on-site review.

Posting the Agendas and File Review List

Approximately one week prior to the on-site review, HSAG posts the agenda and schedules the operational and IS readiness reviews. The agenda lists the proposed date and time for interviews with the vendor's staff members. HSAG always allows the vendor the opportunity to rearrange the interview and file review times to accommodate the needs of its staff members. HSAG also posts the claims testing scenarios the vendor must use to demonstrate its claims adjudication and encounter processing systems.

Approximately one week prior to the review, HSAG posts to the FTP site the list of the files to be audited during the operational on-site visit. After HSAG notifies the vendor that the lists are posted to

the FTP site, the vendor compiles the documents needed for the file reviews to have the information available on the first day of the on-site review.

STEP 7: COMPLETING READINESS REVIEW ACTIVITIES

Opening Conference and Staff Interviews

The first activity that occurs during the on-site review is the opening conference. HSAG staff members introduce themselves and explain their roles for the readiness review activities. The vendor staff members also introduce themselves and may share information about their plan operations. HSAG staff members review the proposed agenda with the vendor's staff members to determine if any adjustments are needed to the agenda or the proposed interview times.

After the opening conference, the readiness review interviews begin. HSAG meets with the key vendor staff members who perform activities associated with each standard to determine the processes for operationalizing the vendor's policies and procedures. HSAG reviewers also ask questions to clarify the information submitted with the pre-on-site documents. HSAG conducts interviews with the vendor staff members to:

- ***Gain a clear and concise understanding of the vendor's ability to meet the regulatory requirements.***
- ***Answer questions from the vendor staff members about the review standards.***
- ***Receive clarification concerning any policies, procedures, and processes presented by the MCO.***
- ***Compare the information gained from reviewing the pre-on-site documents to information gained during the interviews.***
- ***Provide the opportunity for HSAG reviewers to request additional relevant documents that may not have been included in the pre-on-site documentation.***
- ***Process test claims in a live claims adjudication environment using the claims processing scenarios provided by HSAG.***
- ***Review claims monitoring and audit controls.***
- ***Review the MCO's encounter data processes and systems.***

Collecting Other Accessory Information

HSAG's reviewers continually evaluate additional documentation provided during the on-site reviews. Additional documentation may be in the form of committee minutes, reports, documents, or records that were not submitted prior to the audit. HSAG reviewers log each document submitted by the vendor during the on-site review so it may be referenced later.

When conducting the file review, HSAG evaluates the files with a vendor staff member present so the HSAG reviewer may ask the staff member questions and clarify questionable processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the vendor staff member the opportunity to locate the missing information. An element is marked as deficient only if the staff member cannot locate the information needed to satisfy the element on the review tool.

Closing Conference and Exit Interviews

The final activity during the readiness review is the closing conference and the exit interviews. At the end of the readiness review, HSAG conducts a closing summation with the vendor staff to discuss HSAG's comprehension of information obtained during the readiness review process. Vendor staff members may also answer additional questions and present supplementary documentation to clarify an area of concern noted by HSAG.

During the closing conference, HSAG provides information about the next steps in the readiness review process. Next steps involve analyzing the information obtained during the on-site review and compiling the findings from all the HSAG on-site reviewers. During the closing conference, HSAG communicates the approximate timeline for submitting the draft report to the DHCFP and the vendor, as well as the process for submitting a remediation or corrective action plan, should one be required.

Step 8: Analyzing and Compiling Findings

From a review of documents, observations, and interviews with key staff during the readiness review, the HSAG reviewer assigned a score for each element and an aggregate score for each standard for the Operational Readiness Review Evaluation tool and the IS Readiness Desk Review tool. Certain elements are considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, contracting with providers, and capturing enrollment and service information from the DHCFP's MIS to process claims. Each element was given a score of Complete, Incomplete, or Incomplete—Critical.

HSAG's scoring included the following:

- ***Complete indicates full compliance defined as both of the following:***
  - ***All documentation listed under a regulatory provision, or component thereof, is present.***
  - ***Staff members can provide responses to reviewers that are consistent with each other and with the policies and/or processes described in documentation.***
- ***Incomplete indicates noncompliance defined as either of the following:***
  - ***No documentation is present, or documentation is unclear or contains conflicting information that does not address the regulatory requirement.***
  - ***Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.***
  - ***For those provisions with multiple components, key components of the provision cannot be identified and any findings of Incomplete result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.***
- ***Incomplete—Critical indicates noncompliance (previously defined) and requires the MCO to correct a deficiency prior to commencing services.***

Step 9: Reporting Results

Upon compiling the results from the readiness review and determining the level of completeness with each review element, HSAG creates a comprehensive readiness review report that includes a copy of the completed readiness review tools used for the review. The readiness review tools contain the findings for each element reviewed, as well as a description of the areas that are incomplete that require remediation. HSAG also includes a template the vendor uses to document the proposed remediation plans for each requirement that were found to be incomplete.

Following editing and final review by the readiness review team, HSAG sends the report to DHCFP staff members, giving them the opportunity to review the report and provide feedback to HSAG. After HSAG receives feedback, HSAG sends the report with the remediation plan template to the vendor so they may review the report and provide a response to each area that was found to be incomplete.

STEP 10: FACILITATING REMEDIATION PLAN DEVELOPMENT AND APPROVAL

The remediation plan template provided in HSAG's readiness review report contains the findings and recommendation for each element found to be incomplete during the readiness review. The MCO must use the template provided in the report to submit its remediation plan to the DHCFP, which shall detail the MCO's proposed plan to remediate all elements scored Incomplete or Incomplete—Critical. The DHCFP and HSAG typically allow the vendor two weeks to submit the remediation plan using the template provided in the report. While HSAG facilitates the process of collecting the information from the MCO to support its remediation plan, the DHCFP maintains ultimate authority for critical element designation and approving remediation plans submitted in response to the readiness review report.

Once all areas found to be incomplete are remedied by the vendor, HSAG produces a final report that includes the remediation plan completed by the vendor and approved by the DHCFP. This is the final step in the readiness review. HSAG provides the report to the DHCFP and the vendor in hard copy and electronic format. HSAG understands the State retains ownership of all contract deliverables and has the unlimited rights to use, disclose, or duplicate all deliverables produced by HSAG.

Technical Assistance to MCOs on Performance Measures Development

HSAG recognizes that each MCO may be in a different developmental phase, may be staffed differently, and may offer various levels of sophistication and expertise. HSAG staff members will work closely with each MCO's team in developing processes to understand the performance measure methodologies, implement activities and interventions to improve outcomes leading to improved performance measure results, and systems to report performance measure rates. To assist MCOs that are struggling with the performance measure processes, HSAG staff members will participate in frequent conference calls, provide information on best practices and opportunities, and provide suggestions to MCOs regarding external resources that may work collaboratively to improve performance and outcomes.

HSAG finds it invaluable to emphasize the performance measure validation planning process. HSAG will provide the MCOs with technical assistance to develop performance measure processes that allow the MCOs to be successful in reporting all required performance measures in a manner suitable for validation.

HEDIS Compliance Audits or Validation of Measures Using CMS Validating Performance Measures Protocol

As the EQRO for the State of Nevada, HSAG is prepared to validate performance measures for the TANF/CHAP and CHIP expansion populations into the rural counties. HSAG will conduct the performance measure validation activities in accordance with 42 CFR §438.358(b)(1)(ii), using HEDIS specifications or population appropriate methodologies determined by the DHCFP. HSAG has been an NCQA-licensed HEDIS Compliance Audit Organization conducting HEDIS compliance audits since 1998. HSAG has five Certified HEDIS Compliance Auditors (CHCAs) on staff and has established working relationships with other CHCA consultants to ensure all customer validation needs are met in a timely manner.

HSAG understands that while certain performance measures are based on HEDIS specifications, not all performance measures used by the managed care program are HEDIS measures that follow the HEDIS specifications. For example, some of the performance measures identified for the DBA/PAHP are not HEDIS measures, but they are still valuable indicators of performance for a DBA/PAHP. Should the

DHCFP decide to expand managed care to the rural counties, it might also consider expansion of the dental managed care program to the rural counties. HSAG is prepared to conduct HEDIS compliance audits of the MCOs, using the interactive data submission system (IDSS) to submit HEDIS performance measure rates to NCQA. HSAG is prepared to conduct performance measure validation of the DBA/PAHP following the CMS publication, EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. The certified HEDIS compliance audit HSAG performs for MCOs also aligns with the process outlined in the CMS protocol, but there are extra steps and nuances of a certified HEDIS compliance audit that are not specifically outlined in the CMS protocol, such as the IDSS submission. HSAG assures that the HEDIS compliance audit performed for the MCOs meets the requirements outlined in the federal regulations, as well as the CMS protocol. HSAG's proposed approach for validating performance measures, using certified HEDIS compliance audits for MCOs and performance measure validation for the DBA/PAHP, is described in the paragraphs that follow. When the HEDIS compliance activity and performance measure validation activity align, HSAG's description will refer to MCOs and the DBA/PAHP collectively as "vendors." For any deviation, HSAG will specify to which vendor the process refers.

Descriptions of the pre-on-site, on-site, and post-on-site activities to validate performance measures are similar to those described in Section 2.1.3.2 of this proposal with slight modifications detailed in each.

Activity 1: Pre-on-Site Visit Activities

Determine the measure(s) and associated specifications for validation

HSAG will work with the DHCFP to identify the performance measure(s) for validation and to clarify measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification) using the standardized measure specifications. HSAG also will assist in determining the best format to submit the measures.

Prepare the vendor and communicate expectations

HSAG has found it invaluable to emphasize the validation planning process so deadlines and expectations for deliverables are clearly identified and agreed upon. HSAG will provide the vendor with technical assistance to report all required performance measures in a manner suitable for validation. During the initial performance measure validation kick-off call, HSAG will introduce the validation team to the vendor and clearly define roles and responsibilities.

Prepare documentation request

HSAG will provide the DHCFP, for review and approval, a draft documentation request letter and an information collection tool that is appropriate for the audit. The two information collection tools are:

- ***Information Systems Capabilities Assessment Tool (ISCAT), an information collection tool used for performance measure validation and outlined in the CMS protocol***
- ***Record of Administration, Data Management and Processes (Roadmap), an information collection tool prescribed by NCQA to conduct HEDIS compliance audits***

The request letter will detail all required documentation that is needed from the vendor and the associated timelines for completion. Once approved, HSAG will transmit the documentation request and ISCAT/Roadmap to the vendor. HSAG will instruct each vendor to complete either the ISCAT, as described in the CMS protocols, or the Roadmap as described NCQA HEDIS Compliance audit protocol, based on the vendor being audited. HSAG will modify the ISCAT, as necessary, to meet the validation requirements.

The ISCAT and Roadmap are information collection tools that inform the auditor about the vendor's information management system. The ISCAT/Roadmap also collect information on data integration and processes used to determine rates for specific measures. The CMS protocols permit auditors to use the NCQA Roadmap in lieu of the ISCAT to collect information about a vendor and to complete the performance measure validation activity. The ISCAT may only be used for performance measure validation and may not be used for a HEDIS compliance audit. The ISCAT/Roadmap, along with supporting documentation that accompanies it, collects information about the vendor's membership and healthcare delivery environment, data collection tools, common data formats, data file layouts, and results of any data validation studies.

A review of the vendor's ISCAT/Roadmap information will enable HSAG to prepare for on-site visits and clarify any outstanding issues. HSAG will provide technical assistance to each vendor, as needed, to complete the ISCAT/Roadmap and will work to minimize any burden that might be placed on the vendor's staff to complete the documentation request. HSAG has a secure FTP site for the State and each vendor to transfer data and other documents related to the validation activity.

Conduct CAHPS® sample frame validation

Because some of the NCQA HEDIS-based measures can only be captured through a CAHPS survey, HSAG validates the sample frame for the CAHPS survey in accordance with the most recent version of NCQA's HEDIS, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures. The sample frame validation includes a review of specific reporting methods used for HEDIS/CAHPS measures, including:

- ***Detailed evaluation of the computer programming (source code) used to generate the survey sample frame, ensuring its compliance with specifications for survey measures. If the sample frame was generated using a vendor whose measures were certified by NCQA, HSAG ensured that the sample frame method received a Pass status.***
- ***Detailed review of the survey sample frame file elements to verify compliance with the required layout specified in NCQA's current Volume 3: Specifications for Survey Measures, and that the measure-specific eligibility flags were present as applicable.***
- ***Evaluation of membership data completeness.***
- ***Verification that the vendor's survey was administered by an NCQA-Certified HEDIS Survey Vendor.***

HSAG completes the CAHPS sample frame validation activity as part of the MCO HEDIS compliance audit activities.

Review source code

In addition to the ISCAT/Roadmap responses, HSAG will obtain from the vendor the detailed source code and programming logic used to calculate each measure. HSAG programmers, assigned according to familiarity and expertise with the programming language used by each vendor, will conduct a detailed review of each line of code to ensure strict compliance with measure specifications, identify and estimate any potential bias, and identify any necessary corrections.

Assess integrity of the vendor's information systems (IS)

Completing an IS capabilities assessment is a critical validation task that provides valuable feedback to the DHCFP and the vendor on the integrity of the information system and the completeness and accuracy of the data produced by that system. As part of the ISCAT/Roadmap, HSAG will receive detailed information regarding all data systems that feed into the collecting and reporting of performance measures, including patient data, provider data, claims/encounter data, survey data,

and data integration processes. The validation team will review submitted documents to identify system or procedural weaknesses that may impact the accuracy of the performance measure rates. HSAG will review this information before the on-site visit to assist in guiding the team toward specific areas of focus.

Prepare the agenda for the vendor on-site review/interviews

Performing an efficient and effective on-site review requires an agenda that assists the vendor in planning staff participation in interviews, gathering required documentation, and addressing logistical issues such as arranging locations for reviewers to conduct documentation review and interviews. An agenda will set the tone and expectations for the on-site visit, so all participants understand the time frames for the review. HSAG will send a final agenda to each vendor no later than two weeks before the on-site visit.

HSAG will maintain ongoing dialogue with each vendor to enable the organization to prepare for the on-site visit adequately and for the visit to be productive. HSAG's approach is supportive and educational with ongoing correspondence.

Activity 2: On-Site Visit Activities

The CMS and NCQA protocols require an on-site evaluation for the validation of performance measures. HSAG will conduct an on-site visit at each vendor as part of the validation activities. The on-site visit will build on the findings from the pre-on-site document review of the information systems, the source code review, and the assessment of data provided. The on-site activities will include a review of systems that collect and create measure-related data and of data integration processes and performance calculation methodologies performed either in-house by the vendor or by its subcontractor. HSAG's on-site review process will include the following activities as detailed on the agenda:

Conduct opening meeting

The opening meeting will include introductions between the HSAG auditor and the key staff involved in the performance measurement activities. The auditor will explain how he/she will conduct the review and discuss the purpose of the meeting, the required documentation, any queries to be performed, and the sharing of findings with the vendor. Additionally, meeting participants will revisit the agenda and discuss logistics.

Review data management processes

The goal of this session is to determine how the data sources are combined and how the analytic file is produced to report the selected performance measures. Session participants will review backup documentation on data integration and the HSAG auditor will interview staff members regarding software products used during data file production, sampling, and measure computation. The HSAG auditor also will review the data control and security procedures during this session.

Review documentation processes

Documentation review alone is generally insufficient to determine compliance, as content and actual performance of procedures in the documents typically can only be confirmed through interviews with the vendor's personnel. The HSAG auditor will discuss the vendor's documentation processes to collect, store, validate, and report the performance measure data. This session is interactive with key staff members, so the auditor can get a complete picture of all steps that generate the performance measures. The interviews will be used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in

daily practice. The auditor will take notes throughout the interviews to document the review findings. Types of documentation reviewed will include the project work plan, data files, data dictionaries, testing and validation of output files, computer queries, policies and procedures, log files, and database/application manuals.

Evaluate algorithmic compliance

The on-site audit will include a complete information systems assessment that focuses on claims and encounter data, enrollment data, and provider data processing. Additionally, the HSAG auditor will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance. This review will ensure that rate calculations are performed correctly, all data are combined appropriately, and numerator events are counted accurately.

During this session, the HSAG auditor will use several review techniques, including staff interviews, primary source verification, and observation to examine the data collection and reporting processes.

Report performance measures

HSAG will ensure that the vendor has reported the performance measures to the DHCFP using the proper reporting tool and method of delivery, keeping in mind appropriate timelines. The HSAG auditor will ensure that all required measures have been reported as specified by the DHCFP and will note any deviations. The vendor will be instructed to correct any issues.

Conduct closing conference

At the conclusion of the on-site visit, HSAG will conduct a summation conference with key staff members. The intent of this meeting will be to summarize preliminary findings and outline the documentation requirements post-site visit.

Activity 3: Post-Site Visit Activities

The focus of the post-site visit activities includes assessing the vendor's corrective actions and the medical record review validation process as follows:

Assess status of vendor corrective actions

HSAG will track the verbal and written exchange of information throughout the audit and provide recommendations to improve or correct deficiencies. Furthermore, HSAG will ensure that each issue is resolved and will record the dates the vendor corrected the deficiencies and the date HSAG verified that the corrections were made.

Perform medical record review validation

The HSAG medical record review validation team includes experienced registered nurses and professional staff trained in hybrid methodology measure specifications and HIPAA protocols. Beginning with the audit kick-off call, the team will explain and assist each vendor through each step of the medical record review validation process. HSAG will work closely with each vendor to ensure all obstacles that could impact hybrid reported rates are identified and corrected early in the audit. Understanding the various challenges associated with medical record procurement and abstraction within a tight time frame, the medical record review validation team will provide guidance through the following steps:

- ***Step 1: Participate in the initial pre-audit kick-off call.***

- ***Step 2: Review and clarify all ISCAT/Roadmap responses pertaining to the vendor's medical record review process, including reviewer training and quality assurance, medical record procurement approach, and data integration with administrative data and vendor oversight.***
- ***Step 3: Conduct a thorough review of the vendor's selected data abstraction tools, functionality, and reviewer instructions.***
- ***Step 4: Request and review a convenience sample across all hybrid measures. This activity will take place early during the vendor's medical record review process.***

Upon completing the convenience sample review, HSAG's medical record review validation team will provide feedback to the vendor to ensure they are following accurate abstraction practices according to the HEDIS and non-HEDIS hybrid methodology measure specifications. HSAG will:

- ***Provide ongoing support during medical record procurement and abstraction.***
- ***Conduct a final over-read review of multiple hybrid measures.***
- ***Provide corrective actions.***
- ***Assist with the final review of hybrid rates.***

Verification of vendor corrections, verification of patient-level detail file, and final rate review

HSAG will notify each vendor of all findings as soon as possible to allow enough time for corrective action, if necessary. Once all requested follow-up items and any corrective actions are resolved, each vendor will receive a final IS Tracking Grid report that shows the result for each item. HSAG will review the final rates to assess data completeness and accuracy. HSAG also will provide the vendor with a results report that includes a comparison of the preliminary rates and the prior two years' rates (if available), and shows how each rate compares with the national HEDIS benchmarks for HEDIS measures. Any significant increase or decrease in rates will be highlighted with the auditor's feedback/questions. During final rate review, HSAG will compare the final rates with the preliminary rates and note any significant changes. If any errors are discovered during preliminary rate review, the auditor will review the final rates to ensure the errors were corrected.

For HEDIS compliance audits, HSAG and the MCOs are required to use the interactive data submission system (IDSS) to report HEDIS rates to NCQA. As part of this process, HSAG will ensure that the MRR numerator counts in the IDSS submission(s) and rate templates match the lists that the MCO submits in May of each year. For performance measure validation, the HSAG verifies that the final rates reported by the vendor in the final rate sheet supplied by HSAG match the MRR numerator counts. If there are any discrepancies noted by HSAG, in either the IDSS or final rate sheet, the auditor will incorporate these findings and require the vendor to make corrections, as needed. If any vendor declines or is unable to revise a noncompliant methodology, the auditor will assess whether the noncompliance affects reporting and will advise the vendor that noncompliance may result in designating the measures Not Reportable (NR). Once the final rates are confirmed for the HEDIS compliance audit, the CHCA applies its auditor-lock to the IDSS, which is then submitted to NCQA. The auditor will include final measure scoring and any recommendations in the final audit report.

Achieving Uniform Scoring

HSAG uses the standardized rating methodology for performance measure validation as outlined in the current CMS protocol. The following is a list of the validation findings and their corresponding definitions used in assigning uniform ratings.

- ***R = Report: Measure was compliant with state specifications.***
- ***NR = Not Reported: This designation is assigned to measures for which (1) the vendor rate was materially biased or (2) the vendor was not required to report.***

- ***NB = No Benefit: Measure was not reported because the vendor did not offer the benefit required by the measure.***
- ***Additional ratings are also assigned to match the NCQA HEDIS compliance audit designations.***

The HSAG lead auditor ensures that audit team members accurately document their findings and that the findings support the rate designations assigned to the measures. Lead auditors confer with each other and debrief after each audit to confirm that each review is consistent in processes, findings, and scores across the various audit teams and across organizations. HSAG also subjects each report to a validation process that reviews for accuracy of scoring and analytic content, and for consistency across reports.

Report findings

Following the DHCFP's review and approval of the organization-specific draft reports each year, HSAG will provide the vendor with their respective preliminary findings and draft performance measure validation reports, which will incorporate audit findings from the pre-on-site, on-site, and post-site visit activities. The report will consist of a description of the audit process and methodology, a review of standards and data sources, and recommendations for data collection and analysis. The measure validation section will include methods used to obtain documentation, an evaluation of information systems, measure-specific findings, the process to review final reported rates for potential bias, and aggregate and categorical review findings. The report will detail information system capabilities for performance measure data collection and will discuss additional data sources that could potentially be used for future performance measure reporting.

HSAG also will present results of any corrected programming logic, including corrections to numerators, denominators, or sampling used for final measure calculation, as well as any required corrective actions. HSAG will include in the report a summary of major problems identified, corrective actions identified and implemented, follow-up on the corrective action results, and other recommendations to improve the quality of the vendor's data.

In addition, HSAG will present rate results indicating whether the validated measure is reportable or not reportable (due to a material bias in the calculated rate for a measure). Once approved, the DHCFP and each vendor will receive final organization-specific reports. HSAG's final audit reports comply with all NCQA HEDIS compliance audit standards and CMS validation of performance measures reporting requirements, and they provide the vendor with valuable feedback and actionable recommendations for improving performance measure data collection and reporting activities. HSAG will include in the reports the performance measure rate trends and compare those results to national HEDIS and other benchmarks.

HSAG can modify some of the above activities or include additional steps based on the DHCFP's reporting specifications. HSAG's approach to conducting audits allows for quick adjustments based on the State's requirements to modify the report process as needed.

2.1.5.6 At the discretion of the DHCFP, the EQRO may be asked to provide additional technical assistance or consultative services related to EQR activities. All requests for technical assistance or consultative services shall be transmitted in writing from the DHCFP to the EQRO. Each request, at a minimum, will include the following:

A. A description of the major functions, tasks, and activities required;
B. The timeline/due date for any reports or identified deliverables;
C. Specifications as to the medium and/or format of the desired deliverable;
D. A listing of the EQRO's project requirements; and
E. Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or projects expected.

The EQRO will submit to the DHCFP, for approval, its cost proposal for completing the technical assistance or consultative project according to the scope of work detailed in the DHCFP's request.

HSAG understands and will comply with the requirements set forth in 2.1.5.6.A through E.

TECHNICAL ASSISTANCE AND CONSULTATIVE SERVICES

HSAG has collaborated with the DHCFP to provide technical assistance regarding the DHCFP's managed care program since it began providing EQR services to the State of Nevada. While HSAG's contract manager has facilitated most of the technical assistance provided to the DHCFP over the past nine years, HSAG's EQR team brings a wealth of knowledge and expertise in the areas of performance measure development, validation, calculation, and reporting; performance improvement project facilitation and validation; biostatics and complex analytics; network analyses and validation; managed care rules and regulation interpretation; medical record review; survey development and administration; quality rating system development and deployment; managed care expansion; clinical studies; and encounter data validation.

Approach to Providing Technical Assistance

HSAG is prepared to work with the DHCFP to explore and define the technical assistance needs related to EQR activities. HSAG understands the DHCFP's request for technical assistance will be on a case-by-case basis. HSAG is prepared to provide education and technical assistance to the DHCFP to further its quality initiatives and DHHS priorities. HSAG is prepared to provide technical assistance that:

- ***Addresses areas with the highest priority with the probability of producing improvement associated with (1) an aspect of care related to quality, access, timeliness, and/or member health outcomes; (2) improved performance related to meeting specific DHCFP contract requirements; and (3) strategies for engaging providers and members to embrace early detection of disease and illness, early intervention, prevention, and health promotion activities to achieve overall population health.***
- ***Facilitates vendor improvement activities in an area where performance has not met the DHCFP's expectations.***
- ***Facilitates accurate and timely reporting of technical data to CMS or other stakeholders.***

HSAG understands the DHCFP's technical assistance requests may range from basic quality improvement methods to more complex needs, such as measure calculation, data analyses, and specialized reporting. HSAG is prepared to respond to the DHCFP's requests for technical assistance for both the managed care and FFS programs. When requested, HSAG will submit a technical proposal that includes:

- ***A description of the major functions, tasks, and activities to be accomplished by HSAG***
- ***The proposed timeline and associated due dates for any reports or deliverables that result from the activity***
- ***The specifications of the deliverable to be produced, which may include subgroup analyses defined by the DHCFP***
- ***A listing of HSAG's project requirements, such as data file layouts and elements that must be contained in the data extract***
- ***All other associated instructions, definitions, or specifications that must be considered when conducting the activity***

Along with the technical proposal outlined above, HSAG will submit the cost proposal for completing the technical assistance that encompasses the parameters agreed upon by the DHCFP and HSAG staff members.

2.2 QUALIFICATIONS OF EXTERNAL QUALITY REVIEW ORGANIZATIONS

The following are mandatory requirements needed to successfully meet the minimum standards of this RFP. These items are not negotiable.

HSAG understands and attests that it meets and will continue to meet the standards and requirements set forth in 2.2.1 through 2.2.9 of this section.

2.2.1 The vendor and all subcontractors must meet all requirements of 42 CFR 438.354 and the mandatory DHCFP contract requirements as follows:

- 2.2.1.1 The vendor must have staff with demonstrated experience, knowledge and skills of:
  - A. Medicaid recipients, policies, data systems, and processes;
  - B. Managed care delivery systems, organizations, and financing;
- 2.2.1.2 Quality assessment and improvement methods; and
- 2.2.1.3 Research design and methodology, including statistical analysis.

HSAG meets the EQRO competence requirements set forth in 42 CFR §438.354(b). In addition, HSAG's subcontractor, DataStat, meets the competence requirements applicable to its subcontracted scope of services, as described in Section 3.2 of this proposal. HSAG maintains qualified staff with demonstrated experience, knowledge, and skills in the areas of Medicaid recipients, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis. Moreover, HSAG requires its subcontractors to maintain staff with the experience, knowledge, and skills necessary to fulfill the subcontractor's designated duties for its delegated scope of services.

DEMONSTRATED EXPERIENCE, KNOWLEDGE, AND SKILLS

Medicaid Recipients

HSAG currently provides EQR or EQR-related activities in Nevada, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia, respectively. In HSAG's experience, each state's demographics, geography, availability and accessibility of appropriate providers, available resources to serve Medicaid and CHIP members, and state-contracted health plans are all critical factors that contribute to the success of the respective state's Medicaid program to serve its recipients. For existing and continuing EQR customers, such as Nevada, HSAG remains current with state program changes (e.g., waivers and Medicaid expansions), changes in contractors, population-specific characteristics, healthcare challenges, state health priorities, and state or federal regulatory changes that impact the Medicaid and CHIP program and population. HSAG applies this knowledge to its quality assessment and improvement activities.

As the current EQRO for the State of Nevada, HSAG consistently demonstrates its experience and knowledge of the Nevada Medicaid and Check Up program and population characteristics, while providing EQR activities tailored to the State's needs and healthcare priorities and in alignment with the DHCFP's quality strategy.

Medicaid Policies

To ensure compliance with Medicaid policies and processes, HSAG staff members remain fully informed of applicable Medicaid and CHIP laws, regulations, policies, and trends. Additionally, they keep HSAG's EQR contracted states informed of pertinent national healthcare issues, comparable states' standards for Medicaid and CHIP managed care programs, and changes in federal requirements. HSAG's staff members also remain abreast of other healthcare industry standards, such as those of the NCQA, the Joint Commission, the National Quality Forum, and the American Medical Association.

HSAG's staff members are fully versed and competent in CMS EQR protocols. In 2012, HSAG's staff provided CMS with input and feedback on the protocols for conducting EQR activities. CMS incorporated all HSAG input into the current protocols related to performance improvement project (PIP) validation and performance measure validation. In 2017, CMS again sought HSAG's assistance and feedback related to existing EQR protocols, as well as the new protocol under development for validating the adequacy of health plans' provider networks. As new or revised regulations and protocols become effective, HSAG incorporates changes to its compliance review and other quality oversight procedures and projects to comply with the Medicaid and CHIP managed care regulations (Medicaid and CHIP Managed Care Final Rule [CMS 2390-P] effective July 5, 2016).

HSAG's senior staff members serve on national and local committees that address issues and policies germane to the Medicaid/CHIP program. The lessons learned, coupled with Medicaid policy information garnered from HSAG's involvement in these panels and workgroups, is shared with HSAG's State and Corporate Services leadership team to benefit EQRO customers; examples of HSAG's involvement follow.

Gretchen Thompson, MBA, CPHQ, serves as an executive director of HSAG's State and Corporate Services division, and the Nevada contract manager. With more than 20 years of experience in healthcare administration and managed care, Ms. Thompson's expertise spans Medicaid, Medicare, and other publicly funded healthcare systems. She has worked with both public and private entities to develop innovative healthcare programs that demonstrate improved quality of care for the population, as well as reduce program costs.

Ms. Thompson advises states on the evaluation design plans for Section 1115 research and demonstration waivers and 1915(b) independent assessments, and assists states with reporting to CMS. She also provides oversight to the HSAG 1115 Demonstration Management and Evaluation team. Ms. Thompson and the 1115 team provide technical and analytic support to CMS for enhanced evaluation and monitoring of Section 1115 research and demonstration waivers. This includes developing guidance for data collection, analysis, and reporting so that states' evaluations are scientifically valid and inform progress on the CMS Triple Aim. She provides consultative guidance to CMS on delivery system reform incentive project (DSRIP) evaluation, quality metrics and monitoring, and project valuation.

At the request of CMS in 2015, Ms. Thompson served on the technical expert panel for the CMS Oral Health Performance Improvement Project (PIP) Initiative led by CMS in partnership with Mathematica Policy Research, the Children's Dental Health Project, and the Center for Health Care Strategies (CHCS). For this initiative, Ms. Thompson reviewed and provided technical input to the Oral Health PIP Template, Oral Health PIP Manual for States, and Oral Health PIP Manual for Health Plans. Ms. Thompson also served on the expert panel during the Oral Health Improvement national webinar in May 2015.

Bonnie Marsh, MA, BSN, RN, currently serves as HSAG's representative on the duals, MLTSS and Medicaid Innovation Accelerator Program (IAP), and IAP-Community Integration LTSS TEP. CMS contracted with Mathematica Policy Research to develop and implement standardized quality measures to support healthcare delivery reform efforts across CMS' programs that serve Medicare-Medicaid enrollees (also known as dual eligible beneficiaries) and Medicaid-only enrollees. The measures are intended to be meaningful, outcomes-based and not burdensome or duplicative of measures currently available. The role of the TEP is to provide feedback and recommendations to Mathematica Policy Research and its partners (the Project Team) throughout the measure development process. TEP members advise on priority measures for development, measure specifications, testing issues, and key considerations for implementation.

At the request and invitation of CMS, Ms. Marsh presented a plenary session at the Second Annual CMS Medicaid/CHIP Quality Conference. In support of the conference theme of "Improving Care and Proving It," HSAG co-presented, along with a State Medicaid Quality Director (a contractor for HSAG's EQRO services), to showcase new and innovative performance improvement project techniques.

Kim Elliott, PhD, CPHQ, CHCA, Executive Director, presently serves as a standing committee member on the NQF Primary Care and Chronic Illness Committee. Additionally, she serves as a subject matter expert and HSAG representative on four NQF Measure Applications Partnerships (MAP) work groups. The NQF MAP is a public-private partnership that provides input to the DHHS on the selection of performance measures for public reporting and performance-based payment programs, including the Medicare and Medicaid programs. The role of the MAP is to provide feedback and to make recommendations for NQF endorsement of performance measures. NQF-endorsed measures are used by CMS as Medicare performance measures and for the Medicaid adult and child Core Measure Sets. Dr. Elliott's MAP work group involvement includes:

- ***Post-Acute Care-Long-Term Care (PAC-LTC) Workgroup, Individual Subject Matter Expert (Voting), 2014–Present***
- ***Pulmonary and Critical Care Workgroup, Individual Subject Matter Expert (Voting), 2014–2017***
- ***CMS Adult Core Measure Set Workgroup, Individual Subject Matter Expert (Voting), 2014–Present***
- ***CMS Child Core Measure Set Workgroup, Individual Subject Matter Expert (Voting), 2016–2017***

Medicaid Data Systems

HSAG's technical competence is evidenced by its work with a variety of Medicaid data systems and data processing procedures. HSAG analysts possess knowledge and extensive experience in managing and analyzing large data sets. For example, under its contract with the Ohio Department of Medicaid (ODM), HSAG has regularly managed membership data (including eligibility and enrollment), claims data (fee-for-service), and encounter data from Ohio's Medicaid data system for the past five years. HSAG extracts the data received on mainframe tapes from ODM and uses SAS to translate these data from the SAS export file format to a standard text file format. HSAG then processes, indexes, and stores the data in an active data repository from which it performs all analytic activities.

As the EQRO for Colorado, HSAG has maintained secure connections to, and received data from, Colorado's Medicaid data warehouse systems (Cognos/Truven) since 2001. These systems contain member eligibility information, provider data, hospital claims, ambulatory claims, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) encounter data, and pharmacy data. HSAG's responsibility includes scripting, accessing, downloading, and analyzing the data required to calculate the HEDIS measures requested by Colorado, as well as the annual CAHPS sample frames.

In Tennessee, TennCare (the State Medicaid agency) requires an annual evaluation of the adequacy of the complete TennCare provider network, which covers 1.4 million Medicaid managed care members. In addition, HSAG periodically evaluates the completeness and accuracy of the encounter and claims data that care providers submit. These ongoing processes require continual data management in terms of extraction, manipulation, warehousing, and analysis.

Medicaid Processes

Because of its multistate EQRO work, HSAG has gleaned in-depth understanding of the varying Medicaid managed care processes employed by states' health plan contractors of all models and types. HSAG reviews MCOs, PIHPs, PAHPs, and PCCMs (collectively known as managed care entities or MCEs) for compliance with federal and state contract standards in the context of each state's unique requirements, and with the overarching knowledge and understanding of the Medicaid managed care principles related to each operational process (e.g., credentialing, utilization management, provider network development).

Managed Care Delivery Systems

HSAG collaborates with a variety of managed care health plan types (i.e., MCO, PIHP, PAHP, and PCCM) and models (e.g., staff or employment models, administrative services only models, CMOs) to complete EQR activities across its various EQRO-contract states. HSAG has demonstrated experience working with the following:

Primary Care Case Management Programs: ***As one example, HSAG has extensive experience working with the DHCFP's care management organization (CMO), which CMS designated a primary care case management program. HSAG's history working with DHCFP on CMO-related tasks first started in 2012, after the DHCFP issued RFP 1958 to procure the CMO. Soon after, HSAG's executive director provided consultation to DHCFP staff members during the process of negotiating with CMS the special terms and conditions (STCs) of the Nevada 1115 research and demonstration waiver—which governs the HCGP. In March 2014, HSAG performed the readiness review of the DHCFP's CMO to determine the CMO's readiness to perform the obligations of its contract. In December 2014, HSAG completed the compliance review of the CMO to determine if the CMO fully met the provisions of its contract with the DHCFP. Since 2015, HSAG has validated the CMO's non-pay-for-performance (non-P4P) performance measures and provided ongoing technical assistance to the DHCFP regarding the quality improvement activities required by the CMO.***

Medicaid FFS Programs: ***HSAG has provided EQR services for several states' Medicaid FFS programs. The most notable are services for the Nevada Medicaid program since 1999; the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program) beginning in 1990; Hawaii's Medicaid program beginning in 2000; and Colorado's Medicaid program since 2001. For these, HSAG undertakes projects, such as focused studies (e.g., prenatal care, immunization status, access to preventive care for persons with disabilities, and EPSDT services for children); HEDIS calculation or HEDIS report validation studies; consumer satisfaction surveys; clinical reviews of quality and appropriateness; medical utilization review for patients in hospitals and skilled nursing facilities; and long-term care level of care determinations.***

Delivery System Transformations, Expansions, and Transitions: ***HSAG has experience working with numerous states that have implemented significant changes to their Medicaid and/or CHIP delivery models or programs during HSAG's tenure as an EQRO. HSAG has provided technical assistance and customized services to meet the states' needs during these transitions. One such example follows:***

- ***Hawaii Department of Human Services Med-QUEST Division (MQD): In 2009, Hawaii's former FFS Medicaid population (ABD) was transitioned to managed care and members were enrolled into one of two new specialty health plans. For members requiring LTSS, the health plans were responsible for conducting functional assessments and submitting level of care (LOC) requests to HSAG for review and determination of the LOC. Working collaboratively with the MQD during the planning and transition phases, HSAG developed and launched a secure online, real-time Web application with interface capabilities for the Medicaid health plans and providers. The online application and data base provides an automated interface for submission of the LOC requests and significantly reduces the former paper-dependent process, makes information about the status of requests and their approval/denial readily available to users and to the State, and augments the array and timeliness of data-reporting capabilities. HSAG conducted numerous face-to-face and webinar trainings on the application and the State's LOC criteria for all Medicaid providers of long-term care services, the health plans, and the State. User registration grew quickly and exponentially, and HSAG and the MQD received numerous accolades regarding the shift to this online system, its ease of use, and the availability of resources and real-time information on the status of LOC requests. In 2015, Hawaii's managed care model of service delivery transitioned to five integrated health plans responsible for all primary and acute covered services, as well as LTSS. HSAG again supported the State in this transition and adapted its EQR activities, tools, and reports to reflect the unique needs of the new integrated program.***

Managed Care Organizations

HSAG performs EQR activities and services for numerous programs that contract with MCOs, PIHPs, PAHPs, PCCMs, primary care physician programs, care management organizations, and accountable care organizations. HSAG's experience includes working with specialty organizations, such as dental health plans, behavioral health plans, health plans providing long-term services and supports, and health plans serving specialty populations, such as persons with intellectual/developmental disabilities, children/youth in foster care, and persons with HIV/AIDS. HSAG staff members possess a breadth of experience in assessing, designing, and implementing EQR activities for a multitude of managed care delivery systems and organization types, including staff model managed care plans, local initiative models, and county-organized health systems. In addition, numerous HSAG team members bring direct managed care experience to HSAG whenever they join the company. This working knowledge of Medicaid managed care organizations and processes at the state Medicaid agency and/or MCO/PIHP/PAHP/PCCM levels affords HSAG deep understanding of health plan processes, challenges, attributes, and incentives.

Both its knowledge of and experience with Nevada's Medicaid managed care entities make HSAG's Nevada EQRO project team uniquely prepared to work with the DHCFP and its contracted MCOs, PAHP, and CMO immediately upon contract award.

Managed Care Financing

Understanding the financing intricacies of Medicaid managed care organizations is critical to fully understanding a state's EQR needs. HSAG staff members' knowledge of both the capitated and FFS environments, along with incentive payment structures, enables HSAG to make realistic recommendations for improvement. Staff members assist states in developing quality improvement strategies consistent with a state's financing mechanism, as well as developing financial incentive programs based on provider or health plan performance metrics.

Executive Vice President, Richard Potter, has extensive experience in, and knowledge of, healthcare quality systems and performance-based contracting. Mr. Potter also has experience with multiple Medicaid reimbursement methodologies, such as capitated managed care, fee-for-service, premium sharing, and primary care administrative service fee reimbursement. As deputy director for AHCCCS, he worked with Arizona legislators to gain consensus on a defined benefit package, eligibility criteria, and member enrollment process for a $60 million State Premium Sharing Program that provided health insurance to uninsured working individuals and their families.

HSAG recently worked with several state Medicaid agencies to revamp the pay-for-performance approach within their Medicaid programs. For example, HSAG developed a novel pay-for-performance program for Hawaii's Med-QUEST Division, the State's Medicaid agency. The program considered the variable membership mix of each plan; some of the plans were composed of nearly all TANF members, while other plans were composed primarily of ABD members. In addition to considering the mix of TANF and ABD members in each plan, HSAG developed a multi-tiered incentive structure derived from comparisons of performance measure rates relative to national benchmarks, as well as relative improvement in the year-over-year performance measure rates. HSAG's measurement experts also worked with the State Medicaid agency to identify the most pertinent measures for inclusion in the managed care plan incentive program.

In addition to working with state Medicaid agencies, HSAG collaborates with other state entities to develop innovative incentive programs for a variety of provider types. For example, HSAG is currently working with a State public health department to determine incentive payments to all Medicaid-certified skilled nursing facilities within the State based on an evaluation of performance across a wide array of nursing home measures. HSAG was involved in selecting the measures and developing the payout structure.

QUALITY ASSESSMENT AND IMPROVEMENT METHODS

Several types of quality assessment and performance improvement methods with which HSAG staff members have extensive experience include:

Facilitating quality improvement projects: ***HSAG facilitates quality improvement projects to improve quality, accessibility, and timeliness of care for individuals enrolled in Medicaid or CHIP programs. The HSAG PIP team members are subject matter experts with extensive experience implementing quality improvement techniques. For example, the PIP team supports the facilitation of quality and performance improvement projects in its EQRO-contract states and provides training and education to the health plans/state Medicaid agencies on:***

- ***Performing drill-down analysis of health plan data to identify opportunities for improvement***
- ***Process mapping***
- ***Conducting failure modes and effects analysis***
- ***Small-scale intervention testing using Plan-Do-Study-Act cycles***
- ***Developing methods for making fundamental change, such as benchmarking and learning from others; using technology; thinking critically, logically, and creatively about the current system; and using change concepts***
- ***Overcoming quality improvement obstacles***
- ***Developing improvement measures/metrics***
- ***Developing study designs/methodologies***

HSAG also assists states and their health plans with performance improvement activities and projects for a variety of topics, such as:

- ***Reducing avoidable emergency department visits***
- ***Improving coordination and communication of care between physical health and behavioral health plans***
- ***Improving care for members with diabetes***
- ***Ensuring timely initiation of LTSS***
- ***EPSDT services and improving childhood immunization rates***

HSAG's findings of performance trends and the resulting quality improvement recommendations are often the catalyst for state-level policy changes, contract revisions, statewide improvement initiatives, and technical assistance forums.

Assisting states with managed care state quality strategy development and revision: ***In accordance with 42 CFR §438.340, states that contract with managed care entities must draft and implement a written quality strategy to assess and improve the quality of healthcare and services furnished by the entities. The quality strategy must be reviewed and updated as needed, but no less than once every three years. Factors that prompt a review include changes resulting from legislative, state, federal, or other regulatory authority, and/or significant changes to the programmatic structure of the Medicaid program. HSAG remains abreast of CMS requirements for the quality strategy and advises states on developing their quality strategy in accordance with CMS' Quality Strategy Toolkit for States. In addition, HSAG prepares presentations and briefs to update states on new regulations affecting the quality strategy.***

In addition to developing, revising, and annually evaluating Nevada's Quality Strategy, HSAG has assisted Colorado, Hawaii, Illinois, Michigan, Tennessee, and Virginia in the initial development of each state's quality assessment and improvement strategy. Specifically, HSAG makes recommendations for improvement in the care of Medicaid and CHIP members in managed care plans. Additionally, HSAG provides guidance and recommendations for future program development to achieve continuous quality improvement. It has conducted comprehensive evaluations of state quality strategies to determine compliance with the federal Medicaid managed care requirements and to make recommendations on the effectiveness of the strategies. This activity includes HSAG's participation in quality assurance meetings convened by states to review the quality strategy with stakeholders, providers, and health plans.

HSAG also facilitates stakeholder meetings, monitors project progress according to the proposed time frames to ensure the quality strategy is completed on time for CMS submission, and provides feedback and guidance on the initial draft. This technical assistance enables state Medicaid agencies to complete a quality strategy that provides an effective framework to accomplish their goals and objectives.

Additionally, HSAG assists several states in the ongoing evaluation and revision of their quality strategies, using information and outcomes of various quality initiatives, as well as the results of the EQR-related activities HSAG performs for these states.

Validating, calculating, and analyzing HEDIS and other performance measure data: ***Among the core principles of HSAG's quality assessment efforts for Medicaid managed care programs is assuring health plans deliver the highest quality of care based on established standards and requirements. Much of HSAG's monitoring involves compliance with established performance standards, such as HEDIS or other performance measures, thus allowing a comparison of the health plans' performance***

against one another and against national benchmarks. HSAG has conducted HEDIS compliance audits and performance measure validations since 1999, impacting healthcare quality for millions of Medicaid members.

HSAG assists several state Medicaid agencies and their health plans with performance improvement using HEDIS-related data. HSAG provides the states and health plans with information on ways to improve performance pertaining to data collection techniques, data completeness, encounter/claims processing, and quality improvement work groups. Examples of these activities include:

- ***HSAG provides input to the California Medicaid program on performance measure selection and performs on-site audits for the State's Medi-Cal managed care program's selected HEDIS and state-developed performance measures. HSAG provides technical assistance to 26 MCPs throughout the entire audit process and produces preliminary and final plan-specific audit reports for each MCP. For MCPs that also serve the MLTSS population, HSAG validates required performance measures reported for the Medi-Cal-only MLTSS population.***
- ***For the State of Colorado, HSAG conducts an on-site validation of performance measure audit and produces individual reports for each of the five behavioral health organizations (BHOs). Additionally, HSAG prepares annual HEDIS aggregate reports for Medicaid and CHIP that include rates for all physical health plans, and FFS populations. HSAG obtains HEDIS audit reports from the MCOs to calculate a total Colorado performance average. For each HEDIS measure, HSAG compares each MCO's level of achievement with State standards, Colorado's performance average, and national benchmarks to determine whether the results are statistically above, below, or equal to the average. The reports include an explanation of each measure and the HEDIS rates over the past three years, with an analysis of the trends and any limitations for each measure.***
- ***HSAG calculates performance measure rates for Arizona's Medicaid program, AHCCCS', acute care, long-term care, behavioral health services, and Children's Rehabilitative Services programs. HSAG evaluates performance measures in the areas of care for children, care for women, behavioral health, care for chronic conditions, and access to care. Additionally, HSAG evaluates outcome measures in the areas of asthma, COPD, diabetes, and heart failure, as well as utilization measures monitoring emergency department utilization, inpatient utilization, mental health utilization, and 30-day readmission rates.***
- ***For the State of Hawaii, HSAG conducts validation of Medicaid performance measures and performs NCQA HEDIS Compliance Audits™ of the QUEST Integration (QI) health plans in accordance with CMS protocols and NCQA requirements. Validation of the performance measures provides findings related to the collection, calculation, and reporting of HEDIS and non-HEDIS performance measures. The compliance audits include an on-site review of the health plans' information systems and a review of the processes used to collect and calculate the performance measures. HSAG also provides technical assistance for revising and modifying the technical specifications the State of Hawaii Med-QUEST Division (MQD) and QI health plans use to collect and report performance measures.***

<u>Conducting medical record review for clinical and nonclinical quality of care focused studies</u>: HSAG has conducted more than 1 million medical record reviews since it began this activity more than 30 years ago. In each of the completed studies, HSAG uses information from members' medical records to develop actionable recommendations to improve the quality of care for Medicaid members. HSAG's proven track record gives it the experience necessary to use medical record review to translate healthcare information into activities that improve health outcomes for Medicaid populations. Two examples of focused studies using medical record review follow.

- ***An annual focused clinical quality of care study on the immunization status of two-year-old children enrolled in AHCCCS. In a concerted effort to improve the immunization status of children and achieve the immunization goals established by Healthy People 2010, HSAG provided the MCOs with a tool for quality improvement in this area. The primary analysis provided results on the percentage of two-year-old members who were immunized age-appropriately for each of the six HEDIS quality indicators. HSAG provided tabulated results, along with additional analyses, to identify missed opportunities and the extent of partly immunized children, both by health plan and county. HSAG submitted a final report to AHCCCS, the governor, and the Arizona Legislature.***
- ***A focused study/quality improvement project for the management of diabetes to develop quality indicators to assist in planning intervention strategies and health education indicators for the diabetic population served by AHCCCS. During on-site reviews at physicians' offices throughout the State, 48 data elements were collected on approximately 5,000 medical records. HSAG submitted a final report to AHCCCS that included a summary of 16 quality indicators grouped according to specific domains (e.g., physical exam indicators and laboratory processes). The report served as a tool to assist AHCCCS health plans in identifying opportunities and directing intervention efforts to improve the care provided to AHCCCS members. A follow-up study was conducted to track overall improvement.***

Developing and administering surveys: As an industry leader in measuring the effectiveness of healthcare, HSAG has extensive experience in survey management, instrument design, and report development. In 1995, HSAG began to develop health outcomes expertise with surveys that included patient-reported health status, quality of life, and satisfaction. HSAG quickly became a leader in the field by designing and conducting scientifically sound quality-of-life and outcomes studies and by collecting, analyzing, and reporting data for federal and state agencies, managed care plans, hospitals and academic medical centers, and private sector healthcare companies.

HSAG's extensive expertise with surveys enables it to efficiently and effectively integrate CAHPS and other survey results with findings derived from other quality improvement activities to achieve performance improvement. HSAG possesses a wealth of knowledge gleaned from performing CAHPS and related survey work for 14 state Medicaid agencies, including for the DHCFP. HSAG has administered more than 2 million surveys to adult and child Medicaid members in an array of programs (including disabled, TANF, and CHIP members), as well as surveys to evaluate special needs populations, such as the CAHPS Children with Chronic Conditions (CCC) module and Experience of Care and Health Outcomes (ECHO®) Survey.

Conducting encounter data validation: HSAG's experience in conducting encounter data evaluations spans more than 15 years and includes work in physical health, behavioral health, and dental healthcare. HSAG understands that validation of encounter data is critical to ensure data submitted are complete and accurate reflections of the care provided to Medicaid members so that states and health plans can develop improvement initiatives with data that are reliable and comparable across all health plans. For example:

- ***As the EQRO for Colorado, HSAG analyzes claims and encounter data. Prior to conducting an analysis involving claims and encounter data, HSAG performs a comprehensive assessment across key data fields (e.g., dates of service, member ID, provider ID, provider name, diagnosis codes, procedure codes, and other common billing data fields). Additional activities include an evaluation of claims and encounter timeliness (i.e., claims lag triangle evaluation and monthly encounter data volume) and accuracy (i.e., diagnosis and procedure code sequencing and payment accuracy).***

- ***HSAG conducts encounter data validation studies, including administrative and medical record reviews for the State of California. HSAG produces plan-specific and aggregate reports that summarize the findings and include recommendations for DHCS and the MCPs to ensure accurate, complete, and timely encounter data. As needed, HSAG provides technical assistance to the California Medicaid program regarding encounter data quality and completeness. HSAG produced an encounter data improvement guide for the MCOs that highlights the procedures and practices of MCOs that had high encounter data quality. The guide also provides useful tips and improvement strategies for MCOs that seek to improve encounter data quality and accuracy.***
- ***HSAG conducts encounter data validation on the Florida Medicaid agency's (AHCA's) and the MCOs' encounter data for several service types, including dental, pharmacy, inpatient/outpatient, long-term care, and physician visits. HSAG evaluates the accuracy, completeness, and integrity of AHCA's encounter data, as well as the encounter data that MCOs submit. HSAG also performs a medical record review that validates provider-reported encounter data against medical records, and provides technical assistance to MCOs and AHCA on data procurement and study findings. HSAG produces an annual aggregate report of the analysis, findings, and recommendations of the encounter data validation process.***
- ***For Nevada, HSAG initiated an encounter data validation study in August 2017. Although this study is ongoing at the time of this proposal, Nevada's study includes an evaluation of the accuracy, completeness, and integrity of the DHCFP's data for pharmacy, inpatient/outpatient, and physician visits.***

Developing Medicaid consumer report cards: CMS' final rule on managed care in Medicaid and CHIP requires each state contracting with an MCO, PIHP, or PAHP to furnish services to Medicaid members to adopt the Medicaid managed care quality rating system (QRS) developed by CMS or adopt an alternative QRS. QRSs enable states to better measure and manage the quality of care and to assist consumers in selecting a health plan.

HSAG uses its knowledge and experience to develop sound analytic and methodological techniques for producing QRSs and consumer information guides. HSAG's goal in creating consumer report cards is to produce an effective, user-friendly tool to assist state Medicaid agencies with comparing health plan performance and assist beneficiaries in choosing the best plan based on their personal healthcare and service needs. Examples of HSAG's QRS and consumer guide projects are as follows:

- ***As part of the EQRO contract in Illinois, HSAG analyzed 2016 HEDIS results and 2016 CAHPS data from the health plans and used these results to create a consumer report card that compares plan performance. The report card shows how each plan does in providing care and services to their members for specific measures in key performance areas.***
- ***Through its EQRO contract with Ohio, HSAG measures the Medicaid MCPs' performance using access, clinical, and informational performance measures for the ABD and covered families and children (CFC) populations. HSAG is responsible for working with Ohio to update measure specifications, calculate clinical and access performance measure rates, and report the findings for each MCP. HSAG also produces a consumer information guide annually reflecting Ohio MCPs' performance scores.***
- ***HSAG has assisted the State of Michigan for several years with developing composites for the Michigan Medicaid Consumer Information Guide, which consists of integrating different types of performance measures.***

RESEARCH DESIGN AND METHODOLOGY

HSAG's Data Science and Advanced Analytics division has extensive experience conducting analytical projects ranging from case review record sampling and statistical analyses to comprehensive clinical and nonclinical research projects. HSAG has more than 25 years of experience in healthcare informatics, research design, and reporting, including sampling, data management, and statistical analysis. Throughout its extensive history of administrating quality of care studies, HSAG has gained experience in a variety of study designs, clinical conditions, nonclinical areas of service, process and outcome measures, population characteristics, data collection and processing methodologies, statistical analyses, and provider/payer arrangements. From simple random samples to complex multi-stage cluster sampling, and from straightforward performance rates to risk-adjusted weighted averages, HSAG employs experienced analysts with the knowledge to apply appropriate analytic methods to ensure the highest quality studies. More importantly, HSAG's analytic team can translate complex statistical concepts and quantitative and qualitative research into operational goals and standards and improvement activities. A key to HSAG's success is its knowledge of research principles and analytic methods, coupled with the ability to apply them to real-world opportunities for improvement.

HSAG's Data Science and Advanced Analytics team provides both state and federal customers with support in the research areas of methodological design, validity and reliability assessment, data collection and management, statistical sampling, comprehensive data analysis, and customer-tailored report preparation. This team comprises more than 80 analytic professionals with expertise in healthcare informatics, research design, and reporting, including sampling, data management, medical record procurement and abstraction, and statistical analysis. These individuals are highly qualified, with bachelor- and master-level degrees in biostatistics, applied statistics, healthcare economics, epidemiology, and business. In addition, several senior program and management staff members hold doctoral degrees and backgrounds that include research and data analysis.

Along with its knowledge of state Medicaid managed care data systems, HSAG has proven expertise in analyzing and improving Medicaid encounter data. For example, CMS approved the New Hampshire Health Protection Program (NHHPP) Premium Assistance Program for a three-year demonstration in 2014. Under the demonstration, NHHPP beneficiaries received Medicaid benefits by purchasing Medicaid paid health insurance from a qualified health plan on the State's health insurance exchange. HSAG is conducting an evaluation of the NHHPP, using data from several multiple-payer datasets to identify, measure, and analyze the performance and determine the cost-effectiveness of the program in the four performance domains identified by the State: Continuity of Coverage, Plan Variety, Cost-Effective Coverage, and Uniform Provider Access. The multiple-payer datasets include fee-for-service claims and managed care encounters at the person level for the entire State. HSAG also uses person-level eligibility data for the analysis. The analysis includes identifying and selecting appropriate comparison/control groups; data matching across datasets to create person-level summary datasets containing utilization and cost measures of interest, including administrative, medical, and total costs; and several measures related to health outcomes.

SUBCONTRACTOR COMPETENCE AND QUALIFICATIONS: DATASTAT FOR OPTIONAL CAHPS SURVEY ADMINISTRATION

HSAG has selected a highly qualified, experienced subcontractor, DataStat, to perform any optional survey administration activity. DataStat has worked with HSAG for more than 19 years to provide data collection services for CAHPS, as well as for other surveys, and has served as HSAG's

subcontractor on all previous Nevada Medicaid survey activities. DataStat is a NCQA-certified HEDIS survey vendor based in Ann Arbor, Michigan. DataStat employs a research staff of more than 55 professionals and operates a computer-assisted telephone interviewing (CATI) facility with 100 stations and over 100 telephone operators. The strengths and competencies DataStat brings to the State are its combination of a professional design and analysis staff and its extensive data collection and processing capability. Additionally, DataStat has significant experience administering CAHPS surveys to Medicaid beneficiaries across the country in a wide array of languages, including specialized languages and populations, such as Armenian, Chinese, Farsi, Hmong, Ilocano, Khmer, Korean, Lao, Russian, Spanish, and Vietnamese, as well as specific tribal populations in Alaska.

2.2.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities

HSAG understands and will comply with the requirements set forth in 2.2.2.

SUFFICIENT RESOURCES

Physical and Technological Resources

HSAG has the facilities, support services, and office equipment capabilities necessary to conduct all required EQR and EQR-related activities. HSAG is headquartered in Phoenix, Arizona, with satellite offices in Glendale, California; Aurora, Colorado; Tampa, Florida; Honolulu, Hawaii; Columbus, Ohio; Oklahoma City, Oklahoma and Christiansted, U.S. Virgin Islands. Staff members at all locations remain connected through a secure shared network that houses the information system platforms necessary to support the HSAG staff in conducting EQR and related activities. Each of HSAG's office locations is equipped with sufficient furniture, supplies, information technology software, computers and related equipment, phones, teleconferencing equipment, copiers, fax machines, and report production equipment.

HSAG has a dedicated Information Technology (IT) department staffed with experienced software development and IT professionals who provide phone, network, data, application, and website capabilities for HSAG's business operations with 24x7 support. HSAG's high-performance IT systems are based on state-of-the-art technology and processes, and (due to the critical nature of the business, security and continuous availability) are foundational tenets in the design and operation of these systems.

Financial Resources

HSAG is a financially sound, woman-owned, employee-owned, well-managed organization. Founded in 1979, HSAG continues to maintain steady growth and a strong financial position. For fiscal year 2017, HSAG's combined revenues were $95.3 million, with the financial strength to maintain the activities and obligations of a contract resulting from award from Nevada's DHHS DHCFP. HSAG's financial statements are prepared by a certified public accountant and the organization follows generally accepted accounting principles. HSAG's financial strength is a result of its ability to balance growth and working capital. The company's sound financial status provides a solid foundation upon which it continues to expand the number and size of awarded contracts.

HSAG has access to a line of credit with a maximum borrowing base of $6.15 million, and its working capital ratio has been well above industry norms for the last several years, as noted in Table 2.2.2-1 on the following page.

Table 2.2.2-1: Working Capital

Year Ended 6/30	Working Capital Ratio	Gross Revenues
2017	1.87	$95,346,813
2016	1.82	$84,562,648
2015	1.74	$78,377,361

HSAG is subject to the stringent requirements of the Federal Acquisition Regulation. HSAG certifies it has a government-approved accounting system and that both the accounting and estimating systems it uses comply with applicable contract cost principles and procedures. HSAG's Cost Accounting Disclosure Statement has been audited and approved by the Defense Contract Audit Agency (DCAA), and the organization also undergoes an annual Incurred Cost Submission Audit performed by DCAA. HSAG uses CMS-approved cost accounting practices to accumulate, segregate, and report costs.

SUBCONTRACTOR'S SUFFICIENCY OF RESOURCES: DATASTAT FOR OPTIONAL CAHPS SURVEY ADMINISTRATION

DataStat possesses the necessary equipment, facilities, and resources to administer large-scale mail and telephone surveys, including in-house printing/production capabilities and modern, well-equipped CATI survey capabilities. DataStat has in-house groups that specialize in coding, data capture, file creation, editing, tabulation, customized programming, and advanced statistical consultation and analysis.

DataStat typically handles over 100 active survey projects at any given time. The mail production system can go from blank paper to 50,000 completed mail packets per day, with 100 percent video scan accuracy. The DataStat CATI system handles approximately 60,000 hours of interviewing time each year.

DataStat, has developed comprehensive survey management systems to provide complex sample control functions necessary for the successful implementation and administration of all surveys. In designing its systems, DataStat has drawn on its years of experience managing large, complex, mixed-mode surveys.

2.2.3 Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

HSAG understands and will comply with the requirements set forth in 2.2.3.

OTHER CLINICAL AND NONCLINICAL SKILLS

HSAG employs both highly skilled clinical and nonclinical personnel to conduct EQR and EQR-related activities, and employs highly qualified management professionals to lead the organization. President and Chief Executive Officer, Mary Ellen Dalton, PhD, MBA, RN, CHCA, has more than 30 years of direct hands-on, executive-level experience managing healthcare projects, employing quality management and improvement methods for Medicaid health plans. HSAG's Executive Vice President, Rick Potter, MBA, CPA, CHCA, brings more than 20 years of leadership experience in, and knowledge of, healthcare quality systems and managed care programs as they relate to performance-based contracting and Medicaid reimbursement systems. Additionally, HSAG's executive team brings extensive administrative, financial, and clinical leadership experience managing multiple contracts

simultaneously for state and federal agencies. Numerous HSAG staff members hold advanced degrees, including clinical and nonclinical degrees, and/or licenses and certifications. They include registered nurses, social workers, medical doctors, occupational therapists, and PhDs. HSAG employs two full-time chief medical officers currently licensed to practice medicine. In addition, HSAG maintains access to numerous credentialed specialists for peer review and other consultation needs.

HSAG's Oversight of Subcontractor DataStat

The HSAG survey team project leader is in frequent contact with DataStat staff and maintains oversight of survey administration and related activities throughout the entire survey process. For survey administration activities, HSAG reviews sample selection for reasonability, reviews all mail materials prior to production and mailings, validates weekly disposition reports from the subcontractor during fielding, reviews CATI scripts prior to the telephone phase, reviews seed mailings, participates in CATI monitoring sessions and provides feedback to interviewers, and reviews the final raw data file generated by the subcontractor for accuracy and completeness. In addition, HSAG holds formal teleconferences with DataStat to discuss a project's status and any issues or concerns.

2.2.4	Independence. The EQRO and its subcontractors must be independent from the MCO, PAHP, or CMO entities. To qualify as "independent":
2.2.4.1	A State agency, department, university, or other State entity:
2.2.4.2	May not have Medicaid purchasing or managed care licensing authority; and
2.2.4.3	Must be governed by a Board or similar body the majority of whose members are not government employees.

HSAG understands and attests that it complies with the requirements set forth in 2.2.4 and 2.2.4.1 through 2.2.4.3.

HSAG attests that it and its subcontractor, DataStat, are independent from the DHCFP and from the DHCFP-contracted MCOs, DBA/PAHP, and CMO entities they will review. Neither HSAG nor DataStat are a State agency, department, university, or other State entity; therefore, requirements 2.2.4.2 and 2.2.4.3 are not applicable.

2.2.5 As described in (described in §438.354(c)(2)) an EQRO may not:

2.2.5.1 Review any MCO, PIHP, PAHP, or PCCM entity or a competitor operating in the State, over which the EQRO exerts control or which exerts control over the EQRO (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:

A. Stock ownership;
B. Stock options and convertible debentures;
C. Voting trusts;
D. Common management, including interlocking management; and
E. Contractual relationships.

2.2.5.2 Deliver any health care services to Medicaid beneficiaries;

2.2.5.3 Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PAHP, or CMO entity services, except for the related activities specified in §438.358;

2.2.5.4 Review any MCO, PAHP or CMO entity for which it is conducting or has conducted an accreditation review within the previous 3 years; or

2.2.5.5 Have a present, or known future, direct or indirect financial relationship with an MCO, PAHP, or CMO entity that it will review as an EQRO.

HSAG understands and attests that it complies with the requirements set forth in 2.2.5 and 2.2.5.1 through 2.2.5.5.

HSAG further attests that it and its subcontractor, DataStat, meet the EQRO independence requirements set forth in §438.354(c)(2). Specifically, neither HSAG nor DataStat:

- ***Exert control over or have control exerted over them by any Medicaid MCO, PIHP, PAHP, or PCCM entity or a competitor operating in Nevada through the following:***
  - ***Stock ownership***
  - ***Stock options and convertible debentures***
  - ***Voting trusts***
  - ***Common management, including interlocking management***
  - ***Contractual relationships.***

As used here, "control" has the meaning provided in 48 CFR §19.101 [as referenced in 42 CFR §438.354(c)(2)(i)].

- ***Deliver any healthcare services to Medicaid members.***
- ***Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PAHP, or CMO services, except for the related activities specified in 42 CFR §438.358.***
- ***Review any MCO, PAHP or CMO entity for which it is conducting or has conducted an accreditation review within the previous 3 years (HSAG and DataStat do not perform accreditation reviews).***
- ***Have a present, or known future, direct or indirect financial relationship with an MCO, PAHP, or CMO that it will review as an EQRO or subcontractor.***

2.2.6 The vendor must designate a contract manager to work with the assigned DHCFP program specialist or contract monitor(s).

HSAG understands and will comply with the requirements set forth in 2.2.6.

Gretchen Thompson, MBA, CPHQ, will continue in her role as contract manager for the Nevada EQRO contract. Ms. Thompson, Executive Director of State and Corporate Services at HSAG (and the Nevada

contract manager), brings nine years of experience leading and performing EQR activities for the HSAG Nevada EQRO contract. She provides oversight for the development of all contract deliverables and is responsible for the quality of all work performed by project staff, which includes performance improvement project (PIP) validation, review of compliance of State and federal standards, HEDIS audits, network adequacy analysis, validation of the State's quality assessment and performance improvement strategy, and performance measure development, calculation, and validation.

Ms. Thompson and has more than 20 years of experience in healthcare administration and managed care with expertise in Medicaid, Medicare, and other publicly funded healthcare systems. During her tenure at HSAG, she has served as the contract manager for several states. She has worked with both public and private entities to develop innovative healthcare programs that demonstrate improved quality of care for the population, as well as reduced costs for the program. Ms. Thompson develops collaborative partnerships with state Medicaid agencies and internal and external stakeholders, advises states on the direction of their quality initiatives, advises states on the evaluation design plans for Section 1115 research and demonstration waivers and 1915(b) independent assessments, and assists states with reporting to CMS. Ms. Thompson's complete resume is provided in Section VII – Attachment F – Proposed Staff Resume.

As contract manager, Ms. Thompson will:

- ***Serve as HSAG's main point of contact working with the assigned DHCFP program specialist or contract monitor(s)***
- ***Facilitate internal team meetings (weekly during contract start-up and monthly after contract implementation), which will serve as the primary ongoing management mechanism to coordinate activities, delegate tasks, facilitate knowledge transfer among the staff members working on the various activities, and communicate lessons learned***
- ***Assume responsibility for the ongoing monitoring of DHCFP-approved timelines, work flows, and staff resources and will have the authority to commit additional resources, as needed, to meet all contractual requirements***
- ***Prepare and present regular status updates and progress reports to the DHCFP and other stakeholders on the status of EQR activities***

2.2.7	The awarded vendor is, or will subcontract with, a National Committee for Quality Assurance (NCQA) certified Consumer Assessment of Health Plans Survey (CAHPS) vendor, if this optional activity is assigned.

HSAG understands and will comply with the requirements set forth in 2.2.7.

HSAG has served as a CAHPS Survey Vendor since the inception of the program in 1999, and was the first EQRO to become an NCQA-certified HEDIS CAHPS Survey Vendor. As an experienced NCQA-certified HEDIS survey vendor, HSAG ensures CAHPS surveys are administered and analysis conducted in adherence to NCQA HEDIS guidelines.

HSAG subcontractor, DataStat, will conduct the CAHPS data collection for the Nevada EQR CAHPS activities. DataStat possesses the skills and qualifications to efficiently manage a high volume of surveys administered in a prescribed period and provide the most cost-effective and efficient administrative protocol possible. HSAG and DataStat have collaborated on CAHPS activities in 10 states, over multiple years, surveying Medicaid populations and providers.

Detailed information about HSAG's methodology and approach to the administration or validation of consumer or provider surveys are provided in HSAG's response to Sections 2.1.2.2 and 2.1.5.1 (D).

See Section VIII – Other Informational Material, Attachment F – HSAG's NCQA HEDIS (CAHPS) Survey Vendor Certificate for a copy of HSAG's certificate.

See Section VIII – Other Informational Material, Attachment G – DataStat's NCQA HEDIS (CAHPS) Survey Vendor Certificate for a copy of DataStat's certificate.

2.2.8	The awarded vendor is or has on staff, or will subcontract with, an NCQA- Certified Health Employer Data Information Set (HEDIS) Compliance Auditor.

HSAG understands and will comply with the requirements set forth in 2.2.8.

HSAG is one of just nine Licensed Organizations (LOs) certified by the NCQA, and one of three EQROs that are LOs to conduct HEDIS compliance audits. Furthermore, HSAG employs five Certified HEDIS Compliance Auditors (CHCAs) and has established working relationships with CHCA consultants to ensure all customer validation needs are met in a timely manner. Please refer to Section VIII Other Informational Material, Attachment H – Licensed Organization Certificate.

2.2.9	Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor's compliance.

In accordance with Amendment 1, RFP Section 2.2.9 to be deleted in its entirety. No response required.

2.3 VENDOR OPERATING STRUCTURE AND STAFFING

2.3.1 The vendor must assure DHCFP that the organization is adequately staffed with experienced, qualified personnel. The vendor shall provide such assurances as follows:

2.3.1.1 Provide DHCFP with an updated organizational chart whenever a significant change in the organization occurs. The organizational chart must depict each functional unit of the organization, numbers governing the interaction of staff, and relationships with all subcontractors. The organizational chart must also identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the Contract. The names of key personnel must be shown on the organizational chart;

HSAG understands and will comply with the requirements set forth in 2.3.1 and 2.3.1.1. As demonstrated in our proposal, HSAG is adequately staffed with highly experienced team members.

HSAG recognizes the importance of adequately staffing all Nevada EQR activities with well-qualified staff and assures the DHCFP it will meet the personnel commitments described in this proposal. HSAG has served as the EQRO for Nevada since 2000, and has a successful history of managing the Nevada EQRO contract, as well as other large-scale contracts. This success is achieved with:

- ***A focused approach to managing projects that emphasizes efficient and effective achievement of specific outcomes***
- ***A team whose members possess outstanding credentials in terms of years of specialized experience, educational achievements, and professional certifications. Team members are assigned to each activity or task based on their skills and experience in the areas of public health program and policy, HEDIS compliance audits, biostatistics and data analysis, clinical expertise, technology and information systems expertise, medical record reviews, performance measurement, network adequacy, quality improvement project and cost management, and healthcare finance and fiscal control.***
- ***HSAG team members' qualifications and expertise allow them to perform their assigned duties at the project leadership/coordination level, as well as at the level of subject matter experts, activity leads, and assigned staff members.***
- ***HSAG project leaders and coordinators have extensive qualifications, experience, and expertise in managing similarly large complex projects. Staff members have conducted projects for other state Medicaid agencies focused on the same subject matter as the scope of work for the DHCFP.***

The HSAG project team assigned to the Nevada EQRO contract is highly skilled and has experience with Nevada Medicaid, Nevada Check Up, and the Health Care Guidance Program (HCGP), as well as experience from multiple state EQRO contracts. Each activity team lead will serve as a subject matter expert under the direction and supervision of the assigned contract manager, Ms. Gretchen Thompson. Ms. Thompson, brings nine years of experience leading and performing EQR activities for the HSAG Nevada EQRO contract, and over 20 years of experience in healthcare administration and managed care with expertise in Medicaid, Medicare, and other publicly funded healthcare systems.

HSAG commits to the key staff personnel as assigned in this proposal. If a vacancy does occur, proposed replacement personnel will have, at a minimum, the comparable skills and experience of the predecessor and will be sufficiently prepared to assume the duties required by the Nevada EQRO contract.

Resumes for HSAG's proposed staff for the Nevada EQRO contract are included in Section VII – Attachment F – Proposed Staff Resumes. The HSAG Nevada Project Team organizational chart,

provided in Section VIII – Other Informational Materials, Attachment I – Project Team Organizational Chart, provides an overview of the personnel assigned to the Nevada EQRO contract.

2.3.1.2 The vendor must have in place the organizational, management, and administrative systems capable of fulfilling all contract requirements; and

HSAG understands and will comply with the requirements set forth in 2.3.1.2. HSAG has in place the organizational, management, and administrative systems necessary to fulfill all contract requirements.

HSAG has in place the organizational, management, and administrative systems necessary to fulfill all Nevada EQRO contract requirements.

ORGANIZATIONAL SYSTEMS

Physical Resources and Technology Systems

HSAG has the facilities, support services, and office equipment necessary to conduct all required EQR and EQR-related activities. HSAG currently provides EQR or EQR-related activities in Nevada, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia. HSAG has more than 550 employees located at its headquarters in Phoenix, Arizona, and seven satellite offices located in Aurora, Colorado; Glendale, California; Tampa, Florida; Honolulu, Hawaii; Columbus, Ohio; Oklahoma City, Oklahoma; and Christiansted, U.S. Virgin Islands.

HSAG has a dedicated Information Technology (IT) Department staffed with experienced software development and IT professionals who provide phone, network, data, application, and website capabilities for HSAG's business operations with 24x7 support. HSAG's IT systems are based on state-of-the-art technology and processes.

Human Resources

HSAG has personnel policies and procedures to ensure it recruits, hires, trains, and retrains qualified staff members throughout the duration of the contract. By assigning a large, diverse, and experienced team to this project, HSAG's organizational structure will enable knowledge transfer among staff members and teams to mitigate risks associated with vacancies that could occur. In addition, because of HSAG's in-depth pool of talent, positions vacated for a brief period (e.g., vacation) will be backed up and supported internally by a similarly qualified individual familiar with the project.

HSAG ensures that, if a circumstance occurs that would cause the replacement of the contract manager, the replacement will be comparably qualified and sufficiently prepared to assume the leadership duties of the contract. To ensure knowledge transfer occurs and the transition is smooth, a similarly qualified contract manager, with assistance from the HSAG Nevada EQR key personnel, assumes the contract manager duties for an interim period of time. The interim contract manager continues in this role until the permanent replacement has completed a thorough orientation and training and is fully prepared to assume the role as the Nevada contract manager. HSAG will present the résumé of the proposed replacement contract manager to the DHCFP for approval.

HSAG consistently hires capable, responsible, and professional individuals through creative recruiting techniques. It recruits individuals with advanced degrees and additional specialized certifications in healthcare quality improvement (e.g., CPHQ, CPUR, Diplomate ABQAURP, NCQA-certified HEDIS compliance auditors). Recruitment begins with defining the position and developing a position

description. Job descriptions are prepared for every position by the appropriate project or technical staff in conjunction with the Human Resources (HR) Department. The job description identifies the responsibility, authority, experience, technical requirements, and degrees/certifications/licenses required to fulfill the position. Many of HSAG's position descriptions are developed based on unique requirements of a project. HSAG uses the following processes to recruit qualified in-house staff members, consultants, and subcontractors:

- ***Place ads in professional journals and newspapers, and on LinkedIn and other forms of social media, summarizing the duties, educational requirements, and experience required for the position***
- ***Obtain referrals from university personnel with whom HSAG maintains close working relationships***
- ***Sponsor doctoral candidates as interns at HSAG***
- ***Obtain referrals from customers and from current and former employees***
- ***Network with other professional organizations***

MANAGEMENT SYSTEMS

HSAG is a unique organization of highly skilled and experienced senior healthcare professionals working with efficient, organized, and self-directed technical staff members. HSAG attracts staff with a working knowledge of Medicaid managed care processes at the state Medicaid agency and/or the MCO, PIHP, PAHP, and PCCM levels, which provides HSAG customers with a deep understanding of state and health plan processes, challenges, attributes, and incentives.

The HSAG executive and senior leadership team for the Nevada EQRO contract includes:

Mary Ellen Dalton, PhD, MBA, RN, CHCA President and Chief Executive Officer of HSAG, has more than 35 years of experience in Medicare, Medicaid, and the private healthcare industry. She provides strategic vision and direction for HSAG and chairs the Board of Directors for the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) covering contracts in Arizona, California, Florida, Ohio, and the U.S. Virgin Islands. Dr. Dalton also serves on the Board of Directors for four End Stage Renal Disease (ESRD) Networks. She has an extensive background in EQR, and oversees Medicaid contracts in 16 states. In addition, Dr. Dalton is responsible for satellite offices located in California, Colorado, Florida, Hawaii, Ohio, Oklahoma, and the U.S. Virgin Islands.

As a NCQA-certified HEDIS compliance auditor, Dr. Dalton conducts audits of Medicaid, Medicare, and commercial health plans to ensure data collection and reporting procedures comply with HEDIS specifications. In addition, she is credentialed as a Diplomate of The American Board of Quality Assurance and Utilization Review Physicians (ABQAURP).

Dr. Dalton serves on the Board of Directors of Health Current, formerly Arizona Health-e Connection (AzHEC). Moreover, she provides community service as a Board member for a non-profit organization, the Challenge Foundation, where she assists underprivileged children receive middle, high school, and college educations.

Dr. Dalton earned her PhD in 2008 and MBA in 1999 from Arizona State University (ASU), located in Tempe, Arizona. She earned her Bachelor of Science in Allied Health-Specialty in Nursing from The Women's College of the University of Denver (formerly Colorado Women's College), located in Denver, Colorado, in 1977. Dr. Dalton earned her Diploma in Nursing at Helene Fuld College of Nursing, Trenton, New Jersey, in 1970. She practiced Pediatric and Neonatal ICU nursing before entering the administrative and quality improvement fields.

***Richard Potter, CPA, MBA, CHCA**, Executive Vice President and Chief Operating Officer at HSAG, is responsible for overseeing HSAG's Federal Division, including the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contracts.*

Mr. Potter, who has been with HSAG since 2003, has extensive experience in, and knowledge of, healthcare quality systems and managed care programs as they relate to performance based contracting, and in Medicaid reimbursement systems. As a principal with William M. Mercer, Inc., he managed projects to establish risk-adjusted rates, conducted operational and financial health plan reviews, managed quality assurance programs, developed capitation rates, and conducted health plan rate negotiations. As deputy director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, from 1990 to 1998, Mr. Potter designed, planned, and implemented Arizona's CHIP, KidsCare. He also worked with Arizona State legislators to successfully gain consensus on a defined benefit package, eligibility criteria, and a member enrollment process for a $60 million State Premium Sharing Program that provided health insurance to uninsured working individuals and their families. From 1993 to 1996, Mr. Potter was responsible for financial and operational oversight of the AHCCCS acute care health plans, long-term care program contractors, and regional behavioral health authorities. While deputy director, he served as chair of CMS Medicaid Managed Care Technical Advisory Group from 1996 to 1998.

Mr. Potter earned a Master of Business Administration from Arizona State University, located in Tempe, Arizona. He earned a Bachelor of Science in Accounting from California State University at Northridge, California. Mr. Potter is certified by the NCQA as a HEDIS Compliance Auditor.

***Tim Laios, MBA, MPH,** Chief Data Officer and Vice President, Data Science and Advanced Analytics, with more than 20 years of experience leading activities on data and analytic contracts for various customers, including state and federal agencies and departments. He is recognized as a national leader in Medicaid surveys and Medicaid quality reporting systems and is currently serving as a technical expert on the CMS Technical Expert Panel (TEP) which focuses on the Medicaid and CHIP Managed Care Quality Rating System (MAC QRS).*

As the Vice President, Data Science and Advanced Analytics, Mr. Laios oversees a division with over 80 healthcare professionals from a variety of backgrounds. In his current role, Mr. Laios manages numerous CMS contracts related to healthcare research, program evaluation, performance measure development, demonstrations, financial assessments, and performance evaluation. In addition to his work on CMS projects, Mr. Laios has worked with over 25 state Medicaid agencies during his career on a wide array of projects to assess the quality, access, timeliness, and cost-effectiveness of care provided to Medicaid beneficiaries. He currently oversees a wide array of Medicaid analytic activities, including health plan performance assessment, utilization evaluations, readiness reviews, special needs population focused studies, and administration of the CAHPS and other surveys, including quality of life and care management surveys. Over the course of his career, Mr. Laios has supervised the administration of over 2 million surveys to adult and child Medicaid members in a wide array of programs (including both disabled and TANF members), as well as surveys to evaluate special needs populations. He has managed the analysis and reporting of numerous consumer satisfaction surveys, including the CAHPS Medicaid Health Plan Survey, CAHPS-Children with Chronic Conditions (CCC) module, CAHPS PCMH Survey, and CAHPS Dental Plan Survey. He also has experience developing novel survey instruments that evaluate members' experiences with various programs (e.g., care management) and provider satisfaction.

Prior to his work at HSAG, Mr. Laios served as project management lead for the National Informatics Department at Mercer Human Resource Consulting Inc. where he developed the Healthcare Quality

and Disease Management Analytic Group to perform EQR, performance measurement, pay-for-performance, and disease management. He also spent several years working in research at the University of California–Berkeley and for the San Francisco Burden of Disease Study.

Mr. Laios earned a Master of Public Health with a concentration in epidemiology and a Bachelor of Arts in molecular and cell biology, from the University of California, located in Berkeley. He earned a Master in Business Administration with emphasis in healthcare management from Regis University, located in Denver, Colorado.

Carol Smallwood, MPH, Senior Executive Director, HSAG State and Corporate Services division, has more than 30 years of healthcare industry experience with expertise in Medicaid managed care, behavioral health integration, and the affordable care act. She has served in an executive leadership capacity for both private and public healthcare entities, and has contributed to the growth and success of many different companies and projects. In her current role at HSAG, Ms. Smallwood manages a staff of over 60 professionals responsible for the day to day operations of multiple EQRO contracts in various states. Ms. Smallwood works with the executive directors responsible for each state to coordinate internal and external resources to achieve the contractual goals and objectives within the allotted budget and timeframe.

Prior to joining HSAG in 2016, Ms. Smallwood was the vice president of the Customer Care Service for BlueCross BlueShield of Arizona where she planned and created the Customer Care Service Center to serve new members enrolled through the federally facilitated marketplace.

Ms. Smallwood created the community outreach department to provide grassroots outreach and served over 100 community partners and their clientele. She served on the HEDIS workgroup and was appointed by the Board of Directors to serve on the Customer Experience Executive Team. Previously, Ms. Smallwood served as president/CEO for El Paso First Health Plans which served Medicaid and CHIP members in El Paso County and administered a healthcare program for the indigent. She also served as vice president of the El Paso County Hospital District. Ms. Smallwood was the acute care administrator for AHCCCS, where she was responsible for the oversight of the acute care health plans' compliance with contract and Balanced Budget Act (BBA) requirements.

Ms. Smallwood holds a Master of Public Health, with a concentration in Health Administration, from the University of Oklahoma, located in Norman, Oklahoma. She holds a Bachelor of Community Health from New Mexico State University, located in Las Cruces, New Mexico.

Gretchen Thompson, MBA, CPHQ, Executive Director of State and Corporate Services, has more than 20 years of experience in healthcare administration and managed care with expertise in Medicaid, Medicare, and other publicly funded healthcare systems. She has worked with both public and private entities to develop innovative healthcare programs that demonstrate improved quality of care for the population, as well as reduced costs for the program. In her current role at HSAG, Ms. Thompson is responsible for overseeing EQR contracts in several states. She provides oversight for the development of all project deliverables, and is responsible for the quality of all work performed by project staff, which includes performance improvement project (PIP) validation, review of compliance of state and federal standards, HEDIS audits, network adequacy analysis, and performance measure development, calculation, and validation. Ms. Thompson develops collaborative partnerships with state Medicaid agencies and internal and external stakeholders, advises states on the direction of the state's quality initiatives, advises states on the evaluation design plans for Section 1115 research and demonstration waivers and 1915(b) independent assessments, and assists states with reporting to CMS. She also provides oversight to the HSAG 1115 Demonstration Management and Evaluation team. Ms. Thompson and the 1115 team provide technical and analytic support to CMS for enhanced evaluation

and monitoring of Section 1115 research and demonstration waivers. This includes developing guidance for data collection, analysis, and reporting so that states' evaluations are scientifically valid and inform progress on the CMS Triple Aim. She provides consultative guidance to CMS on delivery system reform incentive project (DSRIP) evaluation, quality metrics and monitoring, and project valuation. At the request of CMS in 2015, Ms. Thompson served on the technical expert panel for the CMS Oral Health Performance Improvement Project (PIP) Initiative led by CMS in partnership with Mathematica Policy Research, the Children's Dental Health Project, and the Center for Health Care Strategies (CHCS). For this initiative, Ms. Thompson reviewed and provided technical input to the Oral Health PIP Template, Oral Health PIP Manual for States, and Oral Health PIP Manual for Health Plans. Ms. Thompson also served on the expert panel during the Oral Health Improvement national webinar in May 2015. Previously, Ms. Thompson had been responsible for oversight of the multidisciplinary PIP validation team comprised of clinicians, biostatisticians, and epidemiologists who validate PIPs for 14 states. She also provided oversight of the performance measure validation (PMV)/HEDIS audit team, which audited more than 75 managed care entities annually.

Ms. Thompson earned a Master of Business Administration from the University of Phoenix, located in Phoenix, Arizona. She earned a Bachelor of Arts in Psychology from Arizona State University, located in Tempe, Arizona. She is also a Certified Professional in Healthcare Quality from the Healthcare Quality Certification Commission.

Mariyah Badani, MBA, CHCA, Director of Audits, has oversight responsibility for the validation of HEDIS and performance measures activities for the Nevada EQRO contract. Her current responsibilities include conducting HEDIS compliance audits and performance measure validation audits, developing audit tools, training new auditors, and managing all aspects of the audit process. Ms. Badani has 14 years of experience working with quality initiatives and performance measure validation in the healthcare industry, and more than 24 years of experience in business management with expertise in coordinating and facilitating complex, highly visible, strategic projects that span functional areas with emphasis on cost reduction with increased quality. Her experience includes working collaboratively with government and contractor staffs on project readiness. This includes not only assisting states in identifying appropriate population-specific measures but also providing technical assistance in creating measures. Ms. Badani oversees designated HEDIS compliance audits, performance measure validation, and other state projects through various stages that include recruitment and selection, orientation and training, project design, data abstraction, data collection, and monitoring. Ms. Badani has conducted audits on Medicaid, Medicare, and commercial health plans, and has performed pay-for-performance audits for provider groups and for Medicare-Medicaid plans on behalf of CMS.

Ms. Badani has a Bachelor of Arts degree in psychology and economics, and a Bachelor of Laws degree from the University of Bombay. She also obtained an MBA from Arizona State University and is a certified HEDIS compliance auditor (CHCA).

Christi Melendez, RN, CPHQ, Director of Performance Improvement Projects (PIPs), is responsible for conducting and leading all PIP validation activities and tasks performed by the HSAG PIP Team and ensures that all department and corporate goals and objectives are met. She has more than 30 years of experience in the healthcare industry, with expertise in quality improvement, PIPs, technical assistance, on-site training, healthcare policy and processes, clinical case management, and in working directly with Medicaid populations. Ms. Melendez provides research leadership, analytic expertise, technical interpretive writing, and staff mentoring, as well as ensuring the scientific soundness of study design, analysis, and interpretations of a variety of healthcare studies. She represents the company as needed at regional and national levels.

Ms. Melendez is a registered nurse with an Associate of Science degree in nursing from Cypress College in California. She also is a Certified Professional in Healthcare Quality (CPHQ).

Amber Saldivar, MHSM, BS, Director, leads HSAG's CAHPS and other survey administration activities. Ms. Saldivar has more than 11 years of experience in the healthcare industry with expertise in research, analysis, and reporting. Ms. Saldivar has extensive knowledge and experience with analyzing data at various organizational levels including analyses performed at the patient and provider levels. She has expertise in survey analytic activities, including CAHPS, quality of life, and provider surveys. She has assisted state Medicaid agencies with various EQR activities for over 9 years. Previously, Ms. Saldivar provided support for the national State Financial Alignment Demonstration and managed the development of performance measures for the capitated and managed FFS models so that states and CMS can monitor performance.

Ms. Saldivar earned a Master of Health Sector Management and a Bachelor of Science in finance from Arizona State University, located in Tempe, Arizona.

Amy Kearney, BA, Director, provides management and leadership to the teams conducting the network adequacy validation, focused studies, and validation of encounter data (EDV) activities. With more than 26 years of healthcare industry experience, Ms. Kearney currently directs and coordinates analyst work activities related to projects in support of EQR activities. For more than four years, she has overseen the development and completion of numerous annual EDVs, network adequacy studies, and focused studies. She has experience with all EDV tasks within the CMS protocols and works with states to determine the specific activities to best support each state's evolving encounter data landscape. She provides research leadership, analytic expertise, and mentoring to junior-level staff members. Ms. Kearney acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; supervising staff members; managing customer relations; and providing technical assistance. She assists in developing and implementing staff training related to conducting EQR activities, study design, and execution. Ms. Kearney is accountable for ensuring completion of assigned analytic tasks according to contract specifications and ensuring completed tasks meet budget requirements.

Ms. Kearney earned a Bachelor of Arts degree in business administration at the University of New Mexico–Anderson School of Management.

Raymond Berens, BA, Associate Director, leads HSAG's HEDIS calculations and quality rating system teams. Mr. Berens' responsibilities include working with HSAG customers to develop methodologies and provide meaningful input to states throughout the development, execution, and reporting of healthcare quality projects. Mr. Berens has over 6 years of experience performing analyses of healthcare data, conducting statistical assessments for several state Medicaid agencies, and calculating performance measures utilizing administrative claims data and CAHPS survey data tools. He has expertise in developing state Medicaid P4P program algorithms, selecting metrics for inclusion in payment algorithms, and determining P4P incentive payments. Mr. Berens also oversees all analysis and reporting for the Quality Rating Systems that HSAG produces for Illinois, Michigan, Ohio, and Virginia.

Mr. Berens earned his Bachelor of Arts degree in mathematics from Arizona State University.

Project Management and Oversight

HSAG's approach to project management is based on a matrix style, wherein Gretchen Thompson, MBA, CPHQ, will serve as the contract manager for the Nevada EQR activities and will maintain oversight of the Nevada EQRO contract. Ms. Thompson will be ultimately responsible and accountable

for the project's success and the DHCFP satisfaction. Under her direction, task teams will function to fulfill the requirements of the EQR services contract, including all EQR activities, meetings, reporting, and communications with the DHCFP and MCOs. Each activity lead will serve as a subject matter expert and will work jointly with Ms. Thompson to provide policy advice and support to the DHCFP, as requested.

Each HSAG activity lead, designated as key personnel on the organizational chart included in Section VIII – Other Informational Materials, Attachment I – Project Team Organizational Chart, will be responsible for overseeing the work produced by each functional area's task team and will report the status of each task to the contract manager. Each activity lead is a highly skilled senior healthcare professional experienced in the areas he or she oversees, and are supported by a dedicated team of experienced staff members who possess skills and credentials pertinent to the task area. HSAG's activity leads serve as the DHCFP's consultants, providing knowledge and expert advice on Medicaid managed care issues, policies, and national best practices related to the EQR activities they perform.

In addition to communications through formal update meetings, the DHCFP will receive prompt and personal communications throughout the term of the contract. These communications will serve as an avenue to address the DHCFP's questions and to discuss any developments as they arise. HSAG will keep the DHCFP informed of each task's progress, barriers, successes, and outstanding issues as monitoring procedures unfold. Jointly, the contract manager and the activity lead will present forward-looking ideas to the DHCFP and offer suggestions for enhancements and, as needed, problem-solving.

ADMINISTRATIVE SYSTEMS

Staff Training

Before beginning each Nevada EQRO activity or project, the contract manager will conduct an orientation meeting with all internal staff members assigned to the project. The purpose of this meeting is to review timelines, work assignments, and the scope of project activities and methodologies, and to answer any questions about the Nevada Medicaid, Nevada Check Up, and the Health Care Guidance Program, as applicable.

The contract manager will also provide specific training to staff members to address the unique characteristics of healthcare in Nevada. To provide adequate training for the project staff and continuity for all projects, HSAG uses a skills/competency checklist to ensure individuals assigned to projects possess the necessary skills and competency for the assigned work. The checklist assists management in providing necessary competency-based orientation, training, and cross-training for the project staff.

Peer Review

HSAG uses a process of internal peer review to ensure uniform scoring in its EQR activities. All subject matter experts at HSAG (e.g., compliance, PMV, PIP, and network adequacy validation team members) undergo rigorous training before working with specific states to ensure they are knowledgeable about state-specific contractual requirements in addition to the federal managed care regulations and CMS protocols for the EQR activity. HSAG develops and uses standardized review tools and scoring methodologies. All data collection tools are developed using federal managed care regulations and contract requirements and are based on DHCFP-approved monitoring method(s). Each HSAG draft report is subjected to a validation process that reviews for accuracy of scoring and analytic content, and for consistency across reports. For compliance activities, HSAG assigns an activity lead for

each health plan compliance review. The activity lead is responsible for ensuring consistency of reviewers' monitoring methodology, scoring, and reporting across health plans.

Project Activity Monitoring

HSAG will provide monthly progress reports, organized by EQR task, that summarize the EQR activities to date. The progress report will provide an "accomplishments" column with the status of each activity task and deliverable as of the close of the previous month. In addition, the report will include a listing of "goals" for the subsequent month and any barriers or outstanding issues that should be addressed. The report will assist the DHCFP and the HSAG contract manager to plan and prepare for all necessary steps in the project work plan, ensuring a clearly communicated and coordinated approach. The progress report also will serve as a tracking and monitoring tool for use in HSAG's internal quality control process. In tandem with production of the progress report, HSAG will schedule and conduct telephonic meetings with key DHCFP contacts to review progress, answer questions, review and clarify expectations for the following month, and discuss and address any possible barriers that may pose a risk to timely completion of a timeline milestone or a deliverable. HSAG uses monthly reports and meetings for all its EQRO contract states, and they find this to be an excellent way to identify progress, mitigate barriers, and communicate expectations.

Report Development

For each EQR activity with reporting requirements, HSAG will develop standardized reporting templates for the DHCFP's review, comment, and approval. While reporting on EQR activity results requires certain standardized information elements or sections, HSAG has learned that its state Medicaid agency contractors appreciate the opportunity to receive customized reports that meet the needs of the state and its stakeholders. Therefore, HSAG proposes to work closely with the DHCFP upon contract implementation to determine reporting preferences and develop reporting templates to meet those needs and preferences.

HSAG will work closely with the DHCFP to ensure it understands and conforms to the DHCFP's reporting preferences and requirements. HSAG subjects reports to internal editorial and validation processes to ensure information is accurate and complete, and to ensure the use of reliable processes to analyze and report data and results. Following these processes results in comprehensive reports that are accurate, have valid analytical interpretation, and are of the highest quality.

The HSAG Reports Team, a group of dedicated technical writers and editors, process reports through their final form. The team members bring years of combined higher education and professional experience related to the field. In forming this team, HSAG selected its members because of their college-level training in applicable subjects and their undergraduate and higher degrees in English and in technical and science writing. Team members also have experience in medical and technical publishing and in industry-standard software tools. They maintain their professional skills and keep pace with advances in relevant fields by participating in professional knowledge-sharing activities.

HSAG's written procedures, guidelines, and tracking tools ensure reports (1) meet all timelines and requirements for the deliverable; (2) are professional, accurate, complete, and understandable; and (3) meet the customer's needs and preferences. Written procedures include staff members' roles and specific steps for:

- ***Report planning and creating a timeline.***
- ***Developing the report template.***
- ***Drafting the report.***

- ***Editing the report and validating the information.***
- ***Finalizing the report.***
- ***Delivering the final product to the customer.***

2.3.1.3 The vendor is accountable for and must oversee all subcontractor functions.

HSAG understands and will comply with the requirements set forth in 2.3.1.3.

HSAG has carefully selected its subcontractor, matching strengths to the particular activity. The HSAG contract manager has overall responsibility and accountability for all delegated activities and deliverables. The activity lead under whose direct supervision the subcontractor will perform orients the subcontractor on the contract requirements and delegated responsibilities to ensure tasks and deliverables meet the customers' needs. HSAG's intensive oversight and monitoring of its subcontractors for project management and cost-effectiveness ensures a fully integrated, streamlined, and seamless work process. HSAG performs site visits to each subcontractor location as needed, and maintains regularly scheduled status updates during the term of the contract. For some activities, HSAG holds formal weekly teleconferences to discuss the project's status.

HSAG reviews and approves all work products from subcontractors before the product or information is used in any deliverable submitted to the state Medicaid agency or its managed care organizations. HSAG is the point of contact for all communication with the state Medicaid agency and the managed care entities. The subcontractor does not communicate directly with the state at any time.

HSAG has final responsibility and accountability for its subcontractor and the work performed to meet the requirements of the contract with a state.

HSAG assures the DHCFP that it will follow these accountability and oversight procedures while using DataStat as a subcontractor for the CAHPS activities described in this proposal.

2.4 IMPLEMENTATION

2.4.1	The vendor shall develop and submit to DHCFP for approval, no later than one month after notification that the vendor has been awarded the Contract, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first contract year.

HSAG understands and will comply with the requirements set forth in 2.4.1.

HSAG will develop and submit to the DHCFP for its review and approval an annual written comprehensive work plan and project timeline for implementing the EQRO activities set forth in the contract. No later than one month after notification of contract award, HSAG will submit a work plan and timeline for the first contract year. The detailed work plan and project timeline will adhere to the following outline:

- ***EQR mandatory and optional activities for which HSAG is engaged in the first contract year***
- ***Specific task within each activity***
- ***Timeline for each task***
- ***Responsible party for each task***

HSAG has successfully prepared work plans for the DHCFP in this manner for several years, and uses the workplan and project timeline to monitor activity and task timelines, deliverables, and milestones, as well as to provide an overview of all program activities. At the beginning of the project, HSAG establishes milestones for each activity and deliverable. The project timeline documents all tasks and deliverables for each activity in chronological order by due date, including all reviews, reports, on-site visits, and activities required to complete each task. HSAG monitors each task and records progress on the project timeline. The activity leads maintain responsibility for overseeing the work produced by their assigned activity teams and report the status of each activity task to the contract manager.

HSAG will not begin EQR activities until the DHCFP gives final approval of the work plan and project timeline. If the DHCFP does not approve the plan and timeline, HSAG will resubmit a revised plan and timeline within 10 calendar days of receiving the DHCFP's request for revision.

2.4.2	Provide DHCFP with updates to the initial work plan and timeline, identifying adjustments that have been made to either and describing the vendor's current stage of readiness to perform all Contract obligations. All such updates shall be reviewed and approved by the DHCFP.

HSAG understands and will comply with the requirements set forth in 2.4.2.

The contract manager and activity leads review the workplan and project timeline throughout the life of the activity. When issues arise that may jeopardize meeting timelines, the contract manager will notify the DHCFP. HSAG generally sees three recurring problems when confronting timeline delays. First, MCOs may have difficulty meeting tight deadlines due to staff turnover; second, MCOs may encounter unexpected information system problems; and third, there may be a lack of complete claims or encounter data from either the MCO or the state customer that is needed for specific activities.

HSAG will provide the DHCFP with updates to the initial work plan and timeline on scheduled monthly progress calls, identifying any adjustments made to either and describe its current stage of readiness to perform all contract obligations. The contract manager will discuss all recommended modifications to the work plan or project timeline with the DHCFP and seek approval for the modifications.

2.4.3	Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service start date, all deliverables to permit any DHCFP identified modifications. The DHCFP will have a maximum of twenty (20) working days upon receipt in which to respond with modifications to the vendor. If the DHCFP does not respond by the twentieth work day after receipt of the deliverable, the DHCFP's approval of the submission will be assumed to be granted.

HSAG understands and will comply with the requirements set forth in 2.4.3.

HSAG will supply a list of all deliverables for which it requests modifications be made within 10 working days of the service start date. HSAG understands the DHCFP will have 20 working days from the receipt of the request to respond to the requested modifications/revisions. If the DHCFP does not respond by the 20th working day after receipt, HSAG will assume the DHCFP's approval of the submission is granted.

2.5 PRESENTATION OF FINDINGS

The awarded vendor must obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. This material must protect specific individual recipient privacy and confidentiality to the extent required by both federal and state law and regulation.

HSAG understands and will comply with the requirements set forth in 2.5.

HSAG will obtain the DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. Unless instructed otherwise by the DHCFP, HSAG will only include aggregate information about enrolled recipients so that individual recipient privacy is protected. Historically, the DHCFP has provided aggregate enrollment counts for the managed care program, stratified by managed care vendor, county of residence, race and ethnicity, and age-bands. HSAG uses this information to describe the demographics of the enrolled managed care population in the annual EQR technical report, as well as the DHCFP's quality strategy. HSAG will continue to ensure the material protects specific individual recipient privacy and confidentiality to the extent required by both federal and State law and regulation.

2.6 HIPAA COMPLIANCE REQUIREMENTS

2.6.1 The vendor represents and warrants that:

2.6.1.1 It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations no later than the compliance date of each of those requirements or regulations;

HSAG understands and will comply with the requirements set forth in 2.6.1.1.

HSAG has implemented a thorough Health Insurance Portability and Accountability Act (HIPAA) compliance and protection program that exceeds federal requirements and includes recurring training for all employees, as well as policies and procedures that address the physical and electronic security and day-to-day operations for protecting sensitive health information. HSAG will ensure all data is collected, stored, transmitted, and reported with proven security and data. Given the sensitive nature of the information HSAG is responsible for reviewing, only authorized staff will have access to health information as needed using the most current and authorized data security technologies and processes, such as FTP, Federal Information Processing Standard (FIPS) compliant 256-bit Triple Data Encryption Standard (DES) SSL certificates, encrypted network data storage, encrypted hard disk drives, and dual factor authentication for remote access.

2.6.1.2 It will ensure compliance with all HIPAA standards for themselves and any Business Associate(s), including transaction, code sets, identifier, privacy, confidentiality, and security standards, by the effective date of those rules;

HSAG understands and will comply with the requirements set forth in 2.6.1.2.

HSAG employees and subcontractors sign a Code of Conduct Agreement stating they will abide by all HIPAA, Health Information Technology for Economic and Clinical Health (HITECH), contractual requirements, and HSAG Confidentiality Policies which includes transaction, code sets, identifier, privacy, confidentiality, and security standards.

2.6.1.3 As a Business Associate, the Vendor and all subcontractors will comply with the Business Associate Addendum, ("BAA") found in *Attachment J* that is made a part of the contract.

HSAG understands and will comply with the requirements set forth in 2.6.1.3.

HSAG will comply with the Business Associate Addendum (BAA) provided by the State of Nevada. Additionally, any vendor or subcontractor will be held accountable to the same standards included in the Agreement.

Section VI – Company Background and References

3.1 VENDOR INFORMATION

3.1.1	Vendors shall provide a company profile in the table format below.

In accordance with requirement 3.1, Health Services Advisory Group, Inc.'s (HSAG's) company profile is provided in the table that follows.

Question	Response
Company name:	***Health Services Advisory Group, Inc.***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***Arizona***
Date of incorporation:	***1982***
# of years in business:	***36***
List of top officers:	***Mary Ellen Dalton, PhD, MBA, RN*** ***President and Chief Executive Officer*** ***Joellen Tenison, CPA, MBA*** ***Vice President, Administration and Chief Financial Officer, HSH*** ***Rick Potter, CPA, MBA, CHCA*** ***Chief Operating Officer,*** ***Executive Vice President*** ***Mary Fermazin, MD, MPA*** ***Chief Medical Officer,*** ***Vice President, Health Policy & Quality Measurement*** ***Howard Pitluk, MD, MPH, FACS*** ***Chief Medical Officer and Vice President*** ***Jennifer Goodman, JD, SHRM-OP, PHR*** ***Chief Human Resources Officer*** ***Tim Laios, MBA, MPH*** ***Chief Data Officer, Vice President, DSAA*** ***Dave Kantrud, BS*** ***Chief Information Officer*** ***Andrea Silvey, PhD, MSN*** ***Chief Quality Improvement Officer***
Location of company headquarters, to include City and State:	***3133 E. Camelback Road, Suite 100*** ***Phoenix, Arizona 85016***
Location(s) of the office that shall provide the services described in this RFP:	***3133 E. Camelback Road, Suite 100*** ***Phoenix, Arizona 85016***

Question	Response
Number of employees locally with the expertise to support the requirements identified in this RFP:	***HSAG employs 163 employees at its Phoenix corporate headquarters, all of whom possess the experience and expertise necessary to support the requirements identified in this RFP. This includes both project and support staff.***
Number of employees nationally with the expertise to support the requirements in this RFP:	***HSAG employs 209 employees nationally in its project offices with the expertise to support the requirements in this RFP.***
Location(s) from which employees shall be assigned for this project:	***HSAG will assign employees from its Phoenix, Arizona corporate headquarters, located at: 3133 E. Camelback Road, Suite 100 Phoenix, Arizona 85016***

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

HSAG is not a Nevada-based business and is not claiming this preference.

3.1.3 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

HSAG is currently registered with the State of Nevada, Secretary of State's Office as a foreign corporation since February 17, 2000.

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

HSAG is licensed to conduct business in the State of Nevada, as noted in the response that follows.

Question	Response
Nevada Business License Number:	***NV20001213956***
Legal Entity Name:	***Health Services Advisory Group, Inc.***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	***No***	

If "No", provide explanation.

This item is not applicable.

3.1.5	Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes	*X*	*No*	

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

HSAG is providing the information requested in Table 3.1.5-1 that follows.

Table 3.1.5-1: State Agency Contacts

Question	Response
Name of State agency:	***Department of Health and Human Services, Division of Health Care Financing and Policy***
State agency contact name:	***Theresa Carsten***
Dates when services were performed:	***7/1/2009-6/30/2018***
Type of duties performed:	***External Quality Review Organization***
Total dollar value of the contract:	***$4,702,495.85***

3.1.6	Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		*No*	*X*

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

This item is not applicable.

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

This item is not applicable.

3.1.7	Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

HSAG understands and will comply with the requirements set forth in 3.1.7.

HSAG has had no significant prior or ongoing contract failures, contract breaches, civil or criminal litigation wherein HSAG is alleged to be liable or held liable in a matter involving a contract with the

State of Nevada or any other governmental entity. HSAG has no pending claim or litigation occurring within the past six years which may adversely affect HSAG's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP.

Does any of the above apply to your company?

Yes		***No***	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

This item is not applicable.

Question	***Response***	
Date of alleged contract failure or breach:	***Not applicable***	
Parties involved:	***Not applicable***	
Description of the contract failure, contract breach, or litigation, including the products or services involved:	***Not applicable***	
Amount in controversy:	***Not applicable***	
Resolution or current status of the dispute:	***Not applicable***	
If the matter has resulted in a court case:	***Court***	***Case Number***
	Not applicable	***Not applicable***
Status of the litigation:	***Not applicable***	

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

HSAG understands and will comply with the requirements set forth in 3.1.8.

If awarded a contract, HSAG will review and provide the insurance requirements specified in Attachment D, Insurance Schedule for RFP 3491.

3.1.9	Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

HSAG's Qualifications to Provide the Services

HSAG has carefully studied the DHCFP's Request for Proposal (RFP) and is confident that it is eminently qualified and capable of providing the services required in the manner most advantageous to Nevada Medicaid and Check Up members and the DHCFP. Specifically, HSAG employs highly qualified staff with expertise and experience in providing the requested services, as described in detail in this proposal in Section V, Scope of Work, and Section VII, Proposed Staff Resumes.

For more than two decades, HSAG has actively engaged in evaluating the quality, timeliness, and access to care and services received by individuals enrolled in Medicaid managed care. HSAG provides external quality review (EQR) services in 16 states and is the external quality review organization (EQRO) in 15 of those states. Further, HSAG has provided external quality review (EQR) services to the State of Nevada since 2000. As a highly qualified EQRO and the State's incumbent, HSAG is distinguished from other organizations, as evidenced by the following.

HSAG has:

- ***Served as the EQRO for the Nevada Department of Health and Human Services/DHCFP for more than 18 years. In that time, HSAG has:***
  - ***Demonstrated its knowledge of Nevada Medicaid and Check Up requirements, managed care principles, 1115 research and demonstration waivers, and of Nevada's Medicaid and Check Up programs as well as DHCFP's contracted health plans.***
  - ***Completed production of all required tasks and deliverables in a timely manner.***
  - ***Established excellent working relationships with the DHCFP's assigned contract staff.***
  - ***Facilitated quality initiatives that resulted in:***
    - ***Reduced inappropriate emergency department usage***
    - ***Improved performance across Quality Strategy goals and objectives***
    - ***Early identification of effective intervention strategies that improved performance in areas related to: child health, prenatal care, and mental health follow-up***
    - ***Improved contract compliance by managed care vendors***
- ***Experience working with a variety of health plan models and with organizations that meet the CMS definitions of managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), accountable care organization (ACO), primary care case management (PCCM) entity, as well as other delivery models. HSAG's experience includes support to states and their contractors as new health plan model types, such as the care management organization (CMO) in Nevada, or new populations are integrated into a state's managed care program.***
- ***A unique perspective, given its EQR involvement in 16 states, to share with the DHCFP and its MCOs, DBA/PAHP, and CMO, or future vendor, lessons learned, as well as benchmarks and trends, derived from its extensive EQR activities and data. HSAG can compare a large volume of data from across the states, use lessons learned from other states in implementing programs and managing contractors, and connect the DHCFP with key contacts from other states.***
- ***Extensive experience with Medicaid managed care programs that provide primary and preventive care, managed long-term services and supports (MLTSS), behavioral healthcare and substance use disorder services, dental services, and other specialty services. Additionally, HSAG's experience***

includes collaborating with states' various managed care special needs populations, including aged, blind, and disabled (ABD) populations who require long-term services and supports, and individuals in the Medicaid expansion eligibility groups.

- *Experience conducting readiness reviews prior to new program implementation and prior to newly contracted health plans' "go-live" date; ongoing monitoring following implementation; and review of capacity of the new health plans' medical, behavioral health, dental, and/or long-term care provider networks.*
- *Significant experience in assisting states with, and understands the associated challenges for, Medicaid managed care program implementation and waiver modifications, as well as expansion to statewide or multiregional coverage.*
- *Received national recognition for its quality measure development, evaluation, and policy expertise. The HSAG team has been developing clinical quality measures for the CMS reporting programs for over 10 years. HSAG has developed and maintained 12 measures that have received National Quality Forum (NQF) endorsement and currently holds contracts to develop and maintain measures for both the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program and Qualified Health Plans (QHPs) in the Health Insurance Marketplace.*
- *Since 2012, led the National Impact Assessment of Quality and Efficiency Measures, a triennial report mandated under the Affordable Care Act. This report encompasses the evaluation of the impact of CMS quality measures across 25 reporting programs, and provides policy recommendations to strengthen quality measurement nationally.[15] HSAG was also recently tasked by CMS to develop the CMS Quality Measure Development Plan (MDP),[16] which serves as the strategic framework for measure development for the Quality Payment Program, as mandated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).*

HSAG's commitment to quality is best summarized in its Mission Statement:

> ***We embody quality in all we do: in the services we provide, in the knowledge we share, and in the relationships we build with providers, patients, families, and caregivers. Quality is our way of doing business and directs all of our actions and work.***

HSAG BACKGROUND AND HISTORY

In 1979—following the federal government's implementation of the professional standards review organization (PSRO)—HSAG was established by a group of medical professionals whose mutual goal was to make a difference in healthcare quality improvement. This resulted when President Richard Nixon signed landmark legislation (Public Law 92-603) establishing a peer review system responsible for the comprehensive and ongoing review of services provided under Medicare and Medicaid. The PSRO program was subsequently modified to focus on quality improvement, and HSAG became a quality improvement organization (QIO) for Arizona in 1984.

The Balanced Budget Act of 1997 (BBA) added to the Social Security Act a new section that pertained to Medicaid managed care monitoring. This legislation created the requirement that states contracting with Medicaid managed care organizations must arrange for external quality review performed by a qualified external quality review organization. For more than 20 years, HSAG has competitively bid on and been awarded EQRO and EQR-related services contracts.

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[15] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/national-impact-assessment-of-the-centers-for-medicare-and-medicaid-services-cms-quality-measures-reports.html.

[16] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-mips-and-apms.html.

Since its inception, HSAG has provided innovative leadership on healthcare quality improvement projects for federal, state, and private sector customers, and is one of the most experienced quality improvement and external quality review organizations in the nation. Today, HSAG is recognized as an agent of change in the healthcare industry because of its successful collaboration with states, health plans, and providers across the continuum of care. HSAG's primary roles include providing quality assessment and improvement information and initiatives as:

- ***A Medicaid external quality review organization***
- ***A Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO)***
- ***An End-Stage Renal Disease (ESRD) Network contractor***

In addition, HSAG performs audit services as a Licensed Organization to conduct NCQA HEDIS® Compliance Audits™ [17]), numerous national projects (e.g., CAHPS®[18] Hospital Survey [HCAHPS] and CAHPS for accountable care organizations), and other healthcare quality-related services (e.g., quality improvement plan development, independent waiver assessments).

Medicaid External Quality Review Organization

As the largest EQRO in the nation, HSAG currently provides EQR services in 16 states: Nevada, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia, respectively. HSAG serves as the EQRO in 15 of those states. Collectively, these states enroll more than 13 million Medicaid recipients, representing approximately 45 percent of the nation's Medicaid population. HSAG works collaboratively with state Medicaid agencies for which it performs EQR services to help improve the quality of care provided to Medicaid recipients. Moreover, HSAG collaborates with each state's staff to develop state quality improvement plans and to design initiatives that result in measurable outcomes. HSAG is actively engaged in evaluating the quality of care that Medicaid recipients receive, and has provided EQR-related services for more than 23 consecutive years for Medicaid agencies.

HSAG provides EQR services that include validation of PIPs, validation of performance measures, monitoring compliance with standards in accordance with the federal and state guidelines, validation of network adequacy, production of the EQR technical report, and optional activities (such as validation of encounter data, focused studies, development of quality rating systems, and consumer and provider satisfaction surveys) as set out in the BBA and its resulting EQR regulations. HSAG performs EQRO functions in accordance with federal and state laws, regulations, CMS protocols, state-specific contract requirements, and policies applicable to managed care programs.

Quality Innovation Network-Quality Improvement Organization for Medicare

HSAG remains Arizona's QIO since its first contract was awarded in 1984. In 2003, HSAG became the QIO for Florida and, in 2008, it became the QIO for California. Effective July 2014, CMS regionalized the QIO program through a competitive bidding process and awarded HSAG the largest QIN-QIO contract in the nation. HSAG's QIN-QIO region comprises Arizona, California, Florida, Ohio, and the U.S. Virgin Islands, respectively, which contain approximately 25 percent of the nation's Medicare beneficiaries.

As the QIN-QIO for these five areas, HSAG collaborates with patients, families, caregivers, hospitals, nursing homes, home health agencies, physician offices, and other stakeholders to improve healthcare for Medicare beneficiaries. HSAG collaborates with communities and providers on strategic initiatives

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[17] NCQA HEDIS Compliance Audit is a trademark of the National Committee for Quality Assurance (NCQA).
[18] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

and projects to implement improvements in the quality of care available throughout the spectrum of care for Medicare recipients. QIN-QIO projects drive quality by providing technical assistance, convening learning and action networks, and collecting and analyzing data for improvement.

Pay for Performance (P4P) and Incentive Programs

HSAG recently worked with several state Medicaid agencies to revamp the pay-for-performance approach within their Medicaid programs. For example, HSAG developed a novel pay-for-performance program for Hawaii's Med-QUEST Division, the State's Medicaid agency. The program considered the variable membership mix of each plan; some of the plans were composed of nearly all TANF members, while other plans were composed primarily of ABD members. In addition to considering the mix of TANF and ABD members in each plan, HSAG developed a multi-tiered incentive structure derived from comparisons of performance measure rates relative to national benchmarks, as well as relative improvement in the year-over-year performance measure rates. HSAG also worked with the State to identify the most pertinent measures for inclusion in the managed care plan incentive program.

In addition to working with state Medicaid agencies, HSAG collaborates with other state entities to develop innovative incentive programs for a variety of provider types. For example, HSAG is currently working with a State public health department to determine incentive payments to all Medicaid-certified skilled nursing facilities within the State based on an evaluation of performance across a wide array of nursing home measures. HSAG was involved in selecting the measures and payout structure.

Advanced Analytics for Quality Improvement

HSAG's Data Science and Advanced Analytics department has extensive experience conducting analytical projects ranging from case review record sampling and statistical analyses to comprehensive clinical and nonclinical research projects. HSAG has more than 25 years of experience in healthcare informatics, research design, and reporting, including sampling, data management, and statistical analysis. Throughout its extensive history of administrating quality of care studies, HSAG has gained experience in a variety of study designs, clinical conditions, nonclinical areas of service, process and outcome measures, population characteristics, data collection and processing methodologies, statistical analyses, and provider/payer arrangements. From simple random samples to complex multi-stage cluster sampling, and from straightforward performance rates to risk-adjusted weighted averages, HSAG employs experienced analysts with the knowledge to apply appropriate analytic methods to ensure the highest quality studies. More importantly, HSAG's analytic team can translate complex statistical concepts and quantitative and qualitative research into operational goals and standards and improvement activities. A key to HSAG's success is its knowledge of research principles and analytic methods, coupled with the ability to apply them to real-world opportunities for improvement.

To further demonstrate its experience, Table 3.1.9-1 that follows provides a list of HSAG's EQR services by state. Categorized by state Medicaid agency contract, this table includes the mandatory, optional, and other EQR activities HSAG provides for each state contract that are similar to those outlined in this RFP. HSAG's number of years of experience with each state is provided in the last column.

Table 3.1.9-1: HSAG's Experience Performing External Quality Review Contract Activities

State Medicaid Agency/Department	MANDATORY EQR ACTIVITIES					OPTIONAL EQR ACTIVITIES							OTHER		Total Number of Years' Experience in the State
	Compliance Review	Validation of Performance Measures	Validation of PIPs	Validation of Network Adequacy	Annual EQR Technical Report	Validation of Encounter Data	Validation or Implementation of Member and Provider	Calculation of Performance Measures	Conduct PIPs	Focused Studies	Quality Rating System / Consumer Report Card	Technical Assistance and Training	Readiness Reviews and Additional Monitoring	Quality Strategy Development, Evaluation,	
Nevada, Division of Health Care Financing and Policy	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	18
Arizona, Arizona Health Care Cost Containment System		✓			✓		✓	✓							13
California, Department of Health Care Services		✓	✓	✓	✓	✓	✓			✓		✓		✓	10
Colorado, Department of Health Care Policy and Financing	✓	✓	✓		✓	✓	✓	✓		✓		✓	✓		16
Florida, Agency for Health Care Administration		✓	✓	✓	✓	✓			✓	✓		✓			11
Georgia, Department of Community Health	✓	✓	✓		✓	✓			✓			✓			10
Hawaii, Department of Human Services, Med-QUEST Division	✓	✓	✓		✓	✓	✓					✓		✓	17
Illinois, Department of Health and Family Services	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	14
Iowa, Department of Human Services	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓				2
Michigan, Department of Health and Human Services (MDHHS), Managed Care Plan Division		✓	✓		✓		✓			✓	✓				14
Michigan, MDHHS, Behavioral Health and Developmental Disabilities Administration	✓	✓	✓		✓					✓					15
New Hampshire, Department of Health and Human Services, Office of Medicaid Business and Policy	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓		✓	5
Ohio, Department of Medicaid	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		14
Tennessee, Bureau of TennCare (HSAG is a Subcontractor to the EQRO)	✓	✓	✓	✓	✓	✓				✓		✓	✓		17
Utah, Department of Health	✓	✓	✓	✓	✓							✓			7
Vermont, Agency of Human Services	✓	✓	✓		✓										11
Virginia, Department of Medical Assistance Services	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	4

3.1.10	Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

For more than 23 consecutive years, HSAG has actively engaged in evaluating the quality of care that Medicaid recipients receive, and has provided EQR and EQR-related services since the CMS revised the EQR protocols in 2003. In its role as an EQRO, HSAG has provided the mandatory and optional services described in this RFP for its various contracted state Medicaid agencies, many of which have been customers for over 10 years. The preceding table (Table 3.1.9-1) depicts HSAG's current EQRO activities for 16 states (17 separate contracts) and the total number of years to-date HSAG has provided services for each contract. Additionally, HSAG began performing CAHPS analysis and reporting for the State of Minnesota in July 2016. For nearly 20 years, HSAG has performed HEDIS compliance audits for private sector health plans.

3.1.11	Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information. 3.1.11.1 Dun and Bradstreet Number 3.1.11.2 Federal Tax Identification Number 3.1.11.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement

Dun and Bradstreet Number

HSAG's Dun and Bradstreet number is 11–4443260.

Federal Tax Identification Number

HSAG's federal tax identification number is 86–0440007.

The Last Two (2) Years and Current Year Interim

HSAG is a subsidiary of Health Services Holdings, Inc. (HSH). Included in Section VIII – Other Informational Material, Attachment J – Current Year Interim; Attachment K – 2017 Fiscal Year Financial Statements, and Attachment L – 2016 Fiscal Year Financial Statements are HSH's audited financial statements for the years ended June 30, 2017 and June 30, 2016, and the current year interim Profit and Loss Statement and Balance Sheet as of December 31, 2017 as documentation demonstrating that HSAG possesses the financial resources sufficient to conduct this project.

Profit and Loss Statement

The HSH audited financial statements include HSAG's June 30, 2017 Profit and Loss Statement in the Consolidating Statement of Income and Retained Earnings on page 16 and HSAG's June 30, 2016 Profit and Loss Statement in the Consolidating Statement of Income and Retained Earnings on page 16. HSAG's current year interim Profit and Loss Statement as of December 31, 2017 is included as a separate document.

Please refer to Section VIII – Other Informational Material, Attachment J – Current Year Interim; Attachment K – 2017 Fiscal Year Financial Statements; and Attachment L – 2016 Fiscal Year Financial Statements for HSAG's profit and loss statement.

BALANCE STATEMENT

The HSH audited financial statements include HSAG's June 30, 2017 Balance Sheet in the Consolidating Balance Sheet on page 15 and HSAG's June 30, 2016 Balance Sheet in the Consolidating Balance Sheet on page 15. HSAG's current year interim Balance Sheet as of December 31, 2017 is included as a separate document.

Please refer to Section VIII – Other Informational Material, Attachment J – Current Year Interim; Attachment K – 2017 Fiscal Year Financial Statements; and Attachment L – 2016 Fiscal Year Financial Statements for HSAG's balance statement.

3.2 SUBCONTRACTOR INFORMATION

Subcontractors are defined as a third party, not directly employed by the contractor, who shall provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.

HSAG understands and will comply with the requirements set forth in 3.2.

3.2.1 Does this proposal include the use of subcontractors?

Yes	***X***	***No***	

HSAG will use a subcontractor for the optional activity, Consumer and/or Provider Surveys of Quality Care.

If "Yes", vendor shall:

3.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor shall perform services.

HSAG has carefully selected a highly qualified, experienced subcontractor, DataStat, Inc. (DataStat), to assist with all survey administration activities. DataStat has served as HSAG's subcontractor on all previous Nevada Medicaid survey activities. DataStat is located in Ann Arbor, Michigan and has worked with HSAG for approximately 20 years in providing data collection services for Consumer Assessment of Healthcare Providers and Systems (CAHPS®) as well as for other surveys.19 DataStat is a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) CAHPS vendor and has the capacity to handle large-scale mailing and computer assisted telephone interviewing (CATI) survey administrations[20].

3.2.1.2 If any tasks are to be completed by subcontractor(s), vendors shall:

A. Describe how the work of any subcontractor(s) shall be supervised, channels of communication shall be maintained and compliance with contract terms assured; and

B. Describe your previous experience with subcontractor(s).

HSAG will supervise DataStat, Inc. during all survey-related activities. HSAG will ensure channels of communication are maintained between HSAG and the subcontractor. In addition, HSAG will assure compliance with contract terms.

SUPERVISION OF SUBCONTRACTORS

The HSAG survey team is in frequent contact with staff at DataStat, and maintains survey vendor oversight of DataStat's survey administration activities throughout the duration of the activity. HSAG reviews sample selection for reasonability, all mail materials prior to production and mailings, validates weekly disposition reports from the subcontractor during fielding, reviews CATI scripts before the beginning of the telephone phase, reviews seed mailings, participates in CATI monitoring sessions and provides feedback to interviewers, and reviews the final raw data file generated by the subcontractor for accuracy and completeness. In addition, HSAG holds formal teleconferences with DataStat to discuss the project's status and discuss any issues or concerns.

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

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

PREVIOUS EXPERIENCE WITH SUBCONTRACTORS

DataStat is a proven partner in HSAG's survey work with multiple state Medicaid EQRO contracts and federal CMS contracts. HSAG and DataStat have collaborated on CAHPS or survey-related projects for the following state Medicaid agencies and customers:

- ***Nevada (CAHPS Survey)***
- ***Arizona (CAHPS Survey, Home- and Community-Based Services [HCBS] CAHPS Survey)***
- ***California (CAHPS Survey)***
- ***Colorado (CAHPS Survey, ECHO Survey, CAHPS Patient-Centered Medical Home [PCMH] Survey)***
- ***Hawaii (CAHPS Survey, Provider Survey)***
- ***Michigan (CAHPS Survey, Children's Special Health Care Services [CSHCS] Survey)***
- ***New Hampshire (CAHPS Survey)***
- ***Ohio (CAHPS Survey, Care Management Survey, Quality of Life Survey, Provider Survey)***
- ***Virginia (CAHPS Survey)***
- ***Centers for Medicare & Medicaid (CMS)/NORC (Financial Alignment Initiative [FAI] CAHPS Survey)***
- ***CMS (End-stage renal disease [ESRD] Grievance Satisfaction Survey)***

3.2.1.3	Provide the same information for any proposed subcontractors as requested in Section 3.1, Vendor Information.

HSAG has provided the same information for proposed subcontractor, DataStat, Inc., in Section 3.1, Vendor information, DataStat, Inc.

3.2.1.4	Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

HSAG understands and will comply with the requirements set forth in 3.2.1.4.

3.2.1.5	Vendor shall notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in Section 3.2, Subcontractor Information. The vendor shall receive agency approval prior to subcontractor commencing work.

HSAG understands and will comply with the requirements set forth in 3.2.1.5.

3.3 BUSINESS REFERENCES

3.3.1	Vendors shall provide a minimum of three (3) business references from similar projects performed for private and/or public sector clients within the last three (3) years.

HSAG has provided RFP Attachment E, Reference Questionnaire, to selected references for completion.

Iowa	
Organization	***Bureau of Managed Care Services and Supports*** ***Iowa Medicaid Enterprise*** ***Iowa Department of Human Services***
Hawaii	
Organization	***Med-QUEST Division,*** ***State of Hawaii, Department of Human Services***
New Hampshire	
Organization	***New Hampshire Department of Health and Human Services, Office of Quality Assurance and Improvement***

3.3.2	Vendors shall submit *Attachment E, Reference Questionnaire* to their business references.

HSAG has provided RFP Attachment E, Reference Questionnaire, to its business references for completion.

HSAG has provided RFP Attachment E, Reference Questionnaire, to its subcontractor DataStat, for completion by its business references.

3.3.3	It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in *Section 7, RFP Timeline* for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

HSAG understands and will comply with the requirements set forth in 3.3.3.

3.3.4	The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

HSAG understands the requirement set forth in 3.3.4.

3.4 VENDOR STAFF RESUMES

A resume shall be completed for each proposed key personnel responsible for performance under any contract resulting from this *RFP per Attachment F, Proposed Staff Resume.*

In accordance with requirement 3.4, resumes for each proposed key personnel responsible for performance under this contract are provided in Section VII, Attachment F – Proposed Staff Resumes.

Key personnel resumes for subcontractor, DataStat, are provided as Section VII, Attachment F – Proposed Staff Resumes, of HSAG's response.

3.1 – VENDOR INFORMATION – DATASTAT, INC.

3.1.1	Vendors shall provide a company profile in the table format below.

In accordance with requirement 3.1.1, vendor information for each proposed subcontractor follows.

Question	Response
Company name:	***DataStat, Inc.***
Ownership (sole proprietor, partnership, etc.):	***Partnership***
State of incorporation:	***Michigan***
Date of incorporation:	***March 1988***
# of years in business:	***30***
List of top officers:	***James E. Jeffery, President; Kimberly A Wheeler, Chief Operating Officer***
Location of company headquarters, to include City and State:	***3975 Research Park Dr. Ann Arbor, MI 48108***
Location(s) of the office that shall provide the services described in this RFP:	***3975 Research Park Dr. Ann Arbor, MI 48108***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***0***
Number of employees nationally with the expertise to support the requirements in this RFP:	***43***
Location(s) from which employees shall be assigned for this project:	***3975 Research Park Dr. Ann Arbor, MI 48108***

3.1.2	A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

Because DataStat, Inc. is not a Nevada-based business and is not claiming this preference, this requirement is not applicable.

3.1.3	Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

HSAG will be the prime vendor for this contract. DataStat, Inc. will serve as HSAG's subcontractor. HSAG is currently registered with the State of Nevada, Secretary of State's Office as a foreign corporation since February 17, 2000.

3.1.4	The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

HSAG is the prime vendor for this contract, and DataStat, Inc. will serve as its subcontractor. HSAG is licensed to conduct business in the State of Nevada. Please refer to HSAG's response to Section 3.1.4 of this proposal wherein HSAG provides its Nevada Business License Number and associated information.

Question	Response
Nevada Business License Number:	***Not applicable***
Legal Entity Name:	***DataStat, Inc.***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes		***No***	***X***

If "No", provide explanation.

This item is not applicable.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

HSAG is the prime vendor for this contract, while DataStat, Inc. will serve as its subcontractor. DataStat has never been engaged under contract by any State of Nevada agency.

Yes		***No***	***X***

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

This item is not applicable.

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		***No***	***X***

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

This item is not applicable.

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

This item is not applicable.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

DataStat has not had any significant prior on ongoing contract failures, contract breaches, civil or criminal litigation wherein the vendor is alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity.

Does any of the above apply to your company?

Yes		***No***	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

This item is not applicable.

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

DataStat has provided the information requested in Attachment D.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

DataStat, Inc., located in Ann Arbor, Michigan, has worked with HSAG for more than 19 years in providing data collection services for CAHPS, as well as for other surveys. DataStat is a proven partner in most of HSAG's survey work with multiple state Medicaid EQRO contracts, including Nevada, and federal CMS contracts.

DataStat is an NCQA-certified CAHPS survey vendor. DataStat has an automated, high-capacity mail facility; a Computer Assisted Telephone Interviewing (CATI) facility with 100 stations and over 100 telephone interviewers; and a Web survey facility that runs from in-house servers and is protected by full firewall security and 256-bit encryption. Designed in-house, all facilities are located under one roof. DataStat typically handles over 100 active survey projects at any given time. The mail production system can move from blank paper to 50,000 completed mail packets per day, with 100 percent video scan accuracy. The DataStat CATI system handles approximately 60,000 hours of interviewing time each year. Furthermore, the Web survey system has collected hundreds of thousands of interviews

over the past several years. HSAG's subcontractor possesses the following equipment, facilities, specialty staff qualifications, and services:

- ***All of the necessary equipment and facilities for administering large-scale mail surveys including in-house printing/production capabilities***
- ***Modern, well-equipped CATI survey capabilities***
- ***Extensive data processing and computing resources***
- ***In-house groups that specialize in coding, data capture, file creation, editing, tabulation, customized programming, and advanced statistical consultation and analysis***

In addition, DataStat employs a rigorous confidentiality policy:

- ***The survey management system it employs has been structured such that each element is accessible to only a few key managers, each of whom has signed confidentiality agreements as a condition of employment with the subcontractor. Access to confidential information by unauthorized persons is prevented by having password protected electronic files, locked filing cabinets, and secured areas for storage of data.***
- ***Protocols for identifying security breaches and instituting corrective actions are in place.***
- ***At DataStat, an electronic security system protects the building. The doors are keyed according to a keying plan that provides employees access only to areas that are appropriate to their needs. Only company principals and the facility manager have access to all areas. Visitors must sign in and out and must be accompanied by an employee once past the reception area.***
- ***DataStat is HIPAA compliant with all requirements to date and on schedule to be compliant with all future requirements.***

The CAHPS staff at HSAG are in frequent contact with staff at DataStat and maintain survey vendor oversight of DataStat's survey administration activities throughout the entire process. HSAG reviews sample selection for reasonability, all mail materials prior to production and mailings, validates weekly disposition reports from the subcontractor during fielding, reviews CATI scripts before the beginning of the telephone phase, reviews seed mailings, participates in CATI monitoring sessions and provides feedback to interviewers, and reviews the final raw data file generated by the subcontractor for accuracy and completeness. In addition, HSAG hosts a bi-weekly call with DataStat to review the progress of survey activities and discuss any issues and address any questions.

Background and History

DataStat is a leading provider of survey research services for health and public policy. DataStat routinely conducts survey projects for states, health plans and coalitions, and is very active in the ongoing development of the CAHPS family of instruments. Each year DataStat works with hundreds of health plans to conduct CAHPS and Health Outcomes Survey (HOS) projects.

DataStat's response rates for CAHPS and HOS surveys are consistently among the best. DataStat achieves its rates by building careful attention and detailed intention into each step of each process.

With in-house control of all software, hardware, interviewing and research staff, and all survey processes, DataStat is continuously monitoring and improving every step, from sampling, mail material production and assembly, to CATI programming, interviewers' skills, and report design and production. DataStat's survey management systems—for sample preparation, mail production, CATI fielding, data management, and reporting production—are fully integrated. They are robust enough to accommodate the many active projects that are ongoing at any one point, yet flexible and sensitive enough to allow customization at each stage, simultaneously, for each project.

DataStat has long been involved with the CAHPS family of surveys. One key area has been in the development of CAHPS tools and protocols for non-English languages. DataStat was the first survey organization to implement multi-lingual projects. Over the years, DataStat has maintained the distinction of ensuring data of high reliability in CAHPS surveys translated into Spanish, Korean, Chinese (including Cantonese and Mandarin for telephone follow-up), Hmong, Tagalog, Somali, Farsi, and Russian. DataStat continues to work closely with CAHPS Consortium members who specialize in multi-lingual surveying to conduct field testing, qualitative research and analysis, and project implementation for stakeholders across the country.

A second area of CAHPS work is the development of new materials and protocols, such as the recently released health literacy module designed for implementation in health plan, hospital and provider environments. DataStat was at the forefront of the medical group- and provider-level survey development as well. DataStat was part of the first implementation of the group-level CAHPS data collection and analysis conducted in Massachusetts with Partners Community Health Plan in 1998. This developmental work continued in California, providing the underpinnings of the pay-for-performance initiatives that are now commonplace, and extended to the ACES field testing with medical groups in the Harvard Vanguard network. All of these efforts over the past decade validated the clinician and group survey methodologies and ultimately led to their adoption in the C&G survey tools, sponsored by the CAHPS Consortium.

Projects that DataStat has conducted over the years vary widely in size and scope: from a single academic organization, for example, field testing a single instrument among several hundred selected respondents using a uni-modal protocol, to hundreds of healthcare organizations and hundreds of thousands of respondents state- or nation-wide, using a multi-modal protocol and requiring a multitude of aggregate or individualized custom graphical reports.

DataStat has broad experience and expertise in state-level CAHPS projects. Over the past 15 years DataStat has increasingly specialized in large-scale, state-level projects, such as the statewide CAHPS surveys (HEDIS and non-HEDIS; commercial and Medicaid; with adults, children, Medicare, and other specialized populations) that we now conduct for Utah, New York, Ohio, Minnesota, Washington State, Hawaii, and California. Selected sample sizes for these projects range from 50,000 or so, to well over 100,000, which means that DataStat handles sample frames that are several orders of magnitude larger. Most of these projects run concurrently, with all materials and data collection tools produced and managed in-house.

The following are some of DataStat's selected profiles:

- ***Health Services Advisory Group (HSAG) – statewide surveys. DataStat has a long-standing collaboration with HSAG, an Arizona-based QIO. DataStat and HSAG began work together in 1999 on several Medicaid program surveys. This ongoing collaboration has since expanded to statewide surveys of Medicaid populations across the country, including Nevada, Arizona, Colorado, California, Washington, Michigan, Ohio, and Hawaii***
- ***State of Oregon – Oregon Medical Assistance Program. Since 2001, DataStat has been chosen to implement the CAHPS surveys for the State of Oregon Medicaid, Fee-for-Service, and low-income medical assistance programs. Using an enhanced approach to recommendations by NCQA and the CAHPS Consortium, we use a multi-wave mail plus telephone follow-up mixed methodology to collect the experiences of these beneficiaries.***
- ***State of Utah – DHS Office of Healthcare Statistics. DataStat has worked with the State of Utah since the early 1990's surveying the adult and child Medicaid populations. Utah was one of the very early adopters of the CAHPS survey, and began using it in telephone surveys in 1995.***

DataStat has enjoyed a long and successful relationship with OHCS and the Medicaid plans in Utah.

- *New York State Department of Health (NYSDOH) – CAHPS Adult Medicaid Survey Project. Since 2009, DataStat has been awarded the contract for conducting the CAHPS Adult Medicaid survey project for the NYSDOH. For each survey administration, approximately 35,000 enrollees are sampled across 15-20 managed care organizations. The project uses the current year CAHPS adult Medicaid survey instrument, with additional custom items, for approximately 64 total questions. DataStat implements a mixed-mode protocol consisting of four mailing waves and a telephone follow-up; some years have included a $5 check incentive mailed to respondents who completed a survey. Project data are reported to the National CAHPS Benchmarking Database.*
- *New York State Department of Health – Adult and Child PCMH CAHPS Survey Project. DataStat was selected to conduct the Clinician and Group with PCMH CAHPS Survey for the NYSDOH. The 2013 project was a pilot that consisted of adult and child samples (N=6,000) drawn from PCMH and non-PCMH practices, and used a mixed-mode (3 wave mail plus phone) data collection in English and Spanish. Analysis compared experience of care in PCMH and non-PCMH practices.*
- *In 2015, Data was selected to conduct 5 consecutive years of data collection in conjunction with Public Consulting Group and focused on the Delivery System Reform Incentive Payment Program (DSRIP). The DSRIP survey project surveys the adult populations enrolled in 25 NYSDOH Preferred Provider Systems (PPS); N=37,500. The DSRIP project uses the 2015 C&G CAHPS survey instrument, with some modifications, for approximately 47 total questions, and a mixed mode (mail and telephone) survey protocol in English and pre-identified Spanish. Custom state and PPS-level reports were developed and delivered along with the dataset.*
- *RAND – Work-Associated Carpal Tunnel Syndrome Survey Project. In collaboration with the Worker's Compensation program for California, RAND conducted a study to assess the value of higher quality medical care for Kaiser Permanente members in their treatment of carpel tunnel syndrome (CTS) diagnosed as a verified result of job performance. Approximately 810 individuals were recruited by Kaiser Permanente into the study, and participated in a baseline interview and, for those who completed the baseline, a follow-up CATI interview 18 months later. Interviewing was in English or in Spanish. DataStat consulted on the instrument design and programmed the CATI script, took it through pretest administration to its final version, administered the survey to the full recruited sample at baseline, designed the tracking process of completed cases for the follow-up phase, and conducted the follow-up survey. DataStat provided feedback and a final dataset to RAND at the close of the project.*
- *RAND – PCMH CAHPS for FQHC Advanced Primary Care Demonstration Survey Project. DataStat is currently working with the RAND Corporation (RAND) on its Federally Qualified Health Center Advanced Primary Care Demonstration Survey. The intent of this project is to provide objective, independent performance information to RAND and the CMS regarding patient experience of care received at FQHC sites. The project is using the CAHPS PCMH instrument with some custom items, and a mixed mode data collection: 4-wave mail with telephone follow-up. The target population is Medicare beneficiaries—including dual eligibles—for a total of 30,647 cases. The survey is being conducted in English and Spanish, and accepts proxy respondents who respond on behalf of the named respondent. A follow-up survey will be conducted in 12 months with respondents in the baseline survey.*
- *Minnesota Department of Human Services (DHS) – Statewide CAHPS Medicaid Project. DataStat has worked closely with the Minnesota DHS on several statewide projects since 1999. Foremost is the statewide CAHPS survey of the adult Medicaid population, first awarded to DataStat in 2006, and conducted annually through the present. The goal of the project is to assess consumer*

satisfaction with access and quality of care provided by managed care organizations to enrollees in nine different health plans across six different programs.

Beyond CAHPS and HOS projects, the majority of DataStat's work consists of survey projects conducted in collaboration with researchers from academia, foundations, state and federal agencies, and similar research organizations. Customers include Harvard Medical School, the CDC, the RAND Corporation, the MacArthur Foundation, the NIMH, NCQA, and CMS. DataStat's customer list represents the leading organizations in health services research; projects on which DataStat has collaborated have garnered national attention and recognition.

3.1.10	Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

DataStat has provided survey data collection expertise and services for more than 30 years.

3.1.11	Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information. 3.1.11.1 Dun and Bradstreet Number 3.1.11.2 Federal Tax Identification Number 3.1.11.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement

Dun and Bradstreet Number

DataStat's Dun and Bradstreet number is 19-267-8969.

Federal Tax Identification Number

DataStat's federal tax identification number is 38-2791120.

Last Two (2) Years and Current Year Interim

DataStat is a privately held firm and does not produce an audited financial statement. An independent CPA produces a compilation statement annually, as an adjunct to tax preparation. The line item for Deferred Income Tax is a composite estimate produced based on multiple-source accounting advice.

Because DataStat is closely held and all company shareholders are active partners in the firm, the bottom line results are managed on a year-to-year basis. Incremental capitalization, although rarely needed, is available from company partners as an element of the operating agreement.

DataStat has been in operation for over 30 years, has essentially no long-term debt, adequate bank financing, and a stable financial position. Banking references are available, as appropriate.

Profit and Loss Statement

This requirement is not applicable.

Balance Statement

Please refer to Part III – Confidential Financial Information, Attachment A – Fiscal Year 2014-2016 Balance Sheet for balance statements.

Section VII – Attachment F – Proposed Staff Resumes

A. Vendors shall include all proposed staff resumes per *Section 3.4, Vendor Staff Resumes* in this section.

HSAG is providing resumes for proposed staff listed below beginning on the following page.

Name	Page #	Name	Page #
		Key Staff	
Gretchen Thompson, MBA, CPHQ	***VII.2***	***Amy Kearney, BA***	***VII.10***
Mariyah Badani, MBA, CHCA	***VII.6***	***Christi Melendez, ANS, RN, CPHA***	***VII.13***
Raymond Berens, BA	***VII.8***	***Amber Saldivar, MHSM***	***VII.16***
		Other Staff	
Leslie Arendell, MS	***VII.20***	***Liwen (Laura) Jia, MS***	***VII.53***
Alana Berrett, MPH	***VII.23***	***Julia Lewis, BA***	***VII.56***
Eliza Buyong, MS	***VII.25***	***Jim (Jiaju) Liu, MS***	***VII.59***
Debbie Chotkevys, DHA, MBA	***VII.28***	***Megan McLawhorn, MPH***	***VII.61***
Cheena David, BS	***VII.31***	***Jennifer Montano,***	***VII.63***
Jade Dietzman, BS	***VII.34***	***Kari Pikus, BS***	***VII.66***
Kim Elliott, PhD, CPHQ, CHCA	***VII.36***	***Pooja Rangan, MPH, MBBS***	***VII.68***
Nicole Fair, MS	***VII.40***	***Maureen Sharp, MPH, RN, PMP, CPC***	***VII.71***
Tammy GianFrancisco	***VII.42***	***Robin Tigert, BS***	***VII.74***
Mariana Grass, MPH	***VII.46***	***Lauren Young, MPH, CPH***	***VII.77***
Donald Grostic, MS	***VII.48***	***Tanzida Zaman, MPH***	***VII.80***
Lacy Hinton, AASN, RN	***VII.51***	***Kim Zhang, MSBA***	***VII.82***

B. This section shall also include any subcontractor proposed staff resumes, if applicable.

HSAG is providing a key staff resume for its subcontractor DataStat, Inc.

Name	Page #
Key Staff	
Marielle Weindorf, BA	***VII.85***

Health Services Advisory Group, Inc. (HSAG)
Key Staff Resumes

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Gretchen Thompson, MBA, CPHQ***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Executive Director, State and Corporate Services***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***9***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Thompson has more than 20 years of experience in healthcare administration and managed care, with expertise in Medicaid, Medicare, and other publicly funded healthcare systems. She collaborates with both public and private entities to develop innovative healthcare programs that demonstrate improved quality of care for respective populations, as well as reduce program costs. Ms. Thompson has served as executive director for the Nevada DHCFP EQRO contract since 2009.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***March 2009 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Executive Director, State and Corporate Services***
Contract / Project: ***State of Nevada Division of Health Care Financing and Policy (EQRO contract)***

Contract / Project Details: ***Provides oversight of the development of all EQRO project deliverables for the State of Nevada; responsible for the quality of all work performed by project staff, including performance improvement project (PIP) validation, review of compliance with State and federal standards, Healthcare Effectiveness Data and Information Set (HEDIS®) audits, network adequacy analysis, and performance measure development, calculation, and validation; develops collaborative partnerships with the State's Medicaid agencies and internal and external stakeholders; advises the State on the direction of its quality initiatives; advises the State on the evaluation design plans for Section 1115 research and demonstration waivers and 1915(b) independent assessments; assists the State with reporting to the Centers for Medicare and Medicaid Services (CMS)***

Timeframe: ***January 2009 to September 2012***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***

Position Title:	***Executive Director, State and Corporate Services***
Contract / Project:	***State of Florida Agency for Health Care Administration (EQRO contract)***
Contract / Project Details:	***Provided oversight of the development of all EQRO project deliverables for the State of Florida; responsible for the quality of all work performed by project staff, including performance improvement project (PIP) validation, review of compliance with state and federal standards, HEDIS audits, network adequacy analysis, and performance measure development, calculation, and validation; developed collaborative partnerships with the State's Medicaid agencies and internal and external stakeholders; advised the State on the direction of its quality initiatives; advised the State on the evaluation design plans for Section 1115 research and demonstration waivers and 1915(b) independent assessments; assisted the State with reporting to the Centers for Medicare and Medicaid Services (CMS)***
Timeframe:	***December 2010 to August 2013***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Executive Director, State and Corporate Services***
Contract / Project:	***State of California Department of Health Care Services (EQRO contract)*** ***State of Colorado Department of Health Care Policy and Financing (EQRO contract)*** ***State of Florida Agency for Health Care Administration (EQRO contract)*** ***State of Georgia Department of Community Health (EQRO contract)*** ***State of Hawaii Department of Human Services (EQRO contract)*** ***State of Illinois Department of Healthcare and Family Services (EQRO contract)*** ***State of Nevada Division of Health Care Financing and Policy (EQRO contract)*** ***State of California Department of Health Care Services (EQRO contract)*** ***State of Vermont Agency of Human Services (EQRO contract)***
Contract / Project Details:	***Responsible for the EQRO oversight of a multi-disciplinary PIP validation team comprising clinicians, biostatisticians, and epidemiologists who validated PIPs for the above-referenced state Medicaid managed care programs; provided oversight of the performance measure validation (PMV) HEDIS audit team, which audited more than 75 managed care entities annually***
Timeframe:	***September 2012 to Present***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Executive Director, State and Corporate Services***
Contract / Project:	***CMS MACPIE Subcontract to NORC at the University of Chicago***

Contract / Project Details:	***Provides oversight of the HSAG 1115 Demonstration Management and Evaluation team which provides technical and analytic support to CMS for enhanced evaluation and monitoring of Section 1115 research and demonstration waivers, including developing guidance for data collection, analysis, and reporting to help assure states' evaluations are scientifically valid and inform progress on the CMS Triple Aim; provides consultative guidance to CMS on delivery system reform incentive project (DSRIP) evaluation, quality metrics and monitoring, and project valuation***
Timeframe:	***September 2005 to January 2009***
Company Name:	***Pinnacle Strategies, LLC***
Company Location:	***Chandler, Arizona***
Position Title:	***Principal Consultant***
Contract / Project Details:	***Provided professional consulting services to healthcare organizations, EQROs, and government entities on the following topics: Medicaid and Medicaid/Medicare integrated programs; healthcare policy; state and federal regulatory compliance; evaluations for 1915(b) waivers; improving healthcare for seniors and individuals with disabilities; modernizing the social service system for individuals with disabilities; and removing disincentives to work for individuals with disabilities; provided market research, strategic direction, and business development consulting for a national Medicaid managed care organization; selected by the National Advisory Board on Improving Health Care Services for Seniors and People with Disabilities to author the community mobilization whitepaper, "Declaration for Independence: A Call to Transform Health and Long Term Services for Seniors and People with Disabilities;" served as a technical expert member of the Heinz Family Philanthropies consulting team for projects involving healthcare reform and pharmaceutical purchasing strategies***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Phoenix, Phoenix, Arizona, Master of Business Administration, 2001
Arizona State University, Tempe, Arizona, Bachelor of Arts in Psychology, 1997

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified Professional in Health Care Quality (CPHQ) by the Healthcare Quality Certification Commission, 2000 to Present

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*

Reference #1	
Name *Title*	*Cheryl Austein Casnoff, MPH* *Senior Fellow*
Organization	*NORC at the University of Chicago*
Phone *Fax*	*301.634.9510 Mobile: 301.908.5398* *None*
Email	*Casnoff-cheryl@norc.org*
Reference #2	
Name *Title*	*Gloria MacDonald, CPA* *Retired*
Organization	*(Previously Chief, Program Research and Development, Nevada Division of Health Care Financing and Policy)*
Phone *Fax*	*775.544.0342* *None*
Email	*gmacrex79@charter.net*
Reference #3	
Name *Title*	*Ruthanne Wahlheim, BS, CPHQ* *Associate Director*
Organization	*Empowerment Systems, Inc.*
Phone *Fax*	*480.367.6937 ext. 107 Mobile: 480.236.3809* *None*
Email	*rwahlheim@empowermentsystems.org*

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Mariyah Badani, MBA, CHCA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director, Audits, State and Corporate Services***		
# of Years in Classification:	***4***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Badani has more than 15 years of experience in the healthcare industry, and more than 24 years of business management experience and expertise in coordinating and facilitating complex, highly visible, strategic projects that span functional areas with emphasis on cost reduction with increased quality. Her experience includes working collaboratively with government and contractor staffs on project readiness.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***July 2014 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Director, Audits***

Contract / Project:

State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Hawaii Department of Human Services (ERQO contract)

State of Illinois Department of Healthcare and Family Services (ERQO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

State of Vermont Agency of Human Services (EQRO contract)

Contract / Project Details: ***Responsible for assisting states with ensuring the successful completion of the validation of performance measures, including identifying appropriate population specific measures and providing technical assistance in creating measures as needed; provides additional guidance provided in the form of training to State staff, as well as the managed care organizations, to ensure validation leads to***

reportable and actionable rates; contributes to the EQRO technical report, as prescribed in 45 CFR §438.364.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Executive Master of Business Administration, 2007
University of Mumbai, Mumbai, Maharashtra, India, Bachelor of Arts, Psychology and Economics, 1991

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified Six Sigma Black Belt, 2011
Certified HEDIS® Compliance Auditor (CHCA), 2015

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name Title	Michael Kriofsky Vice President, Operations
Organization	UMR (a UnitedHealthcare company)
Phone Fax	715.841.7037 None
Email	Mike.kriofsky@umr.com
Reference #2	
Name Title	Maneet Sahni Sr. Director, Client Services
Organization	Optum Global Solutions
Phone Fax	952.205.0862 / 952.715.8337 None
Email	maneetsahni@optum.com
Reference #3	
Name Title	Valerie Collier Quality Program Manager
Organization	Virginia Department of Medical Assistance Services (DMAS)
Phone Fax	804.786.2273 None
Email	Valerie.Collier@dmas.virginia.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Raymond Berens, BA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Associate Director, Data Science and Advanced Analytics***		
# of Years in Classification:	***6.5***	**# of Years with Firm:**	***6.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Mr. Berens has experience performing analyses of healthcare data and conducting statistical assessments for several state Medicaid agencies. He calculates performance measures using administrative and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data. Additionally, Mr. Berens has experience developing state Medicaid pay-for-performance (P4P) program algorithms, selecting metrics to include in payment algorithms, and determining P4P incentive payments. He evaluates programs across a myriad of evaluation units, including analyses performed at the health plan, nursing home, health home, and/or hospital levels. Mr. Berens applies his in-depth understanding of mathematics and symbolic logic to practice, while conducting statistical analysis tasks and functions.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***September 2011 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Associate Director***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Arizona Health Care Cost Containment System (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of California Department of Public Health Quality and Accountability Supplemental Payment Program

Contract / Project Details: ***Assists states with performance measure calculation and/or Quality Rating System activities, including assistance with the review and selection of performance measures, data collection, data validation, performance measure calculation, rate reviews, deliverable preparation, and presentation of results to stakeholders; contributes to EQRO technical report, as prescribed in 45 CFR §438.364***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Bachelor of Arts, Mathematics, magna cum laude, 2004

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Michael Shults*** ***Consultant***
Organization	***California Department of Public Health***
Phone ***Fax***	***916.319.9571*** ***None***
Email	***Michael.Shults@cdph.ca.gov***
Reference #2	
Name ***Title***	***Sylvia Riperton-Lewis*** ***Chief, Bureau of Quality Management***
Organization	***Illinois Department of Healthcare and Family Services***
Phone ***Fax***	***312.793.1357*** ***None***
Email	***Sylvia.RipertonLewis@Illinois.gov***
Reference #3	
Name ***Title***	***Guoyong Wang*** ***Research Scientist III***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5334*** ***None***
Email	***Guoyong.Wang@dhcs.ca.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Amy Kearney, BA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director, Data Science and Advanced Analytics***		
# of Years in Classification:	***4.5***	**# of Years with Firm:**	***4.75***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Kearney has more than 27 years of experience in the healthcare industry and Medicaid, and oversees the development and completion of annual encounter data validation studies, focused studies, and network adequacy studies for numerous state customers.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***April 2013 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Director, Data Science and Advanced Analytics***

Contract / Project:

State of Nevada Department of Health and Human Services Division of Health Care Financing and Policy (EQRO contract)

State of Arkansas Department of Medicaid Services (Data Mining and Program Evaluation contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration, (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Office of Medicaid Business and Policy Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Division of TennCare (EQR subcontract)

	Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)
Contract / Project Details:	***Directs and coordinates analyst work activities related to Data Science and Advance Analytics division projects in support of external quality review (EQR) activities; provides research leadership, analytic expertise, and mentoring to analytical staff regarding encounter data validation studies, focused studies, and network adequacy studies in various states; serves as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; supervises staff; manages customer relations; provides technical assistance; maintains and monitors company-customer relationships and ongoing customer satisfaction for assigned contracts; assists in the development and implementation of staff training related to conducting EQR activities, study design and execution; ensures completion of assigned analytic tasks according to contract specifications, contributes to the EQRO technical report as prescribed in 45 CFR §438.364.***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of New Mexico-Anderson School of Management, Albuquerque, New Mexico, Bachelor of Business Administration, 1996

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified, Licensed Analyst of the Predictive Index® System, 2005
TriWest Project Management Certification, 2008
TriWest Lean Six Sigma Yellow Belt Certification, 2009

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Anna Lee Amarnath, MD, MPH*** ***Medical Program Consultant & Section Chief, Medi-Cal Managed Care***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5039*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***
Reference #2	
Name ***Title***	***Jason Holst*** ***Quality Improvement Analyst,*** ***Bureau of Managed Care Services and Supports***
Organization	***Iowa Department of Human Services***
Phone ***Fax***	***515.974.3070*** ***None***
Email	***jholst@dhs.state.ia.us***

Reference #3	
Name ***Title***	***Rachel La Croix, Ph.D., PMP*** ***AHC Administrator, Performance Evaluation and Research Unit***
Organization	***Bureau of Medicaid Quality, Agency for Health Care Administration***
Phone ***Fax***	***850.412.4670*** ***None***
Email	***Rachel.LaCroix@ahca.myflorida.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc. (HSAG)***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Christi L. Melendez, ASN, RN, CPHQ***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director, Performance Improvement Projects (PIPs)***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***17***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Melendez has more than 30 years of experience in the healthcare industry, with expertise that spans quality improvement, performance improvement projects (PIPs), technical assistance, on-site training, healthcare policy and processes, and clinical case management, and direct collaboration with Medicaid and Medicare populations.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***January 2006 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Director, Performance Improvement Projects (PIPs)***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Georgia Department of Community Health (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Utah Department of Health (EQRO contract)

State of Vermont Agency of Human Services (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Successfully conducts performance improvement project implementation and validation activities; provides oversight of all PIP-related deliverables and activities; provides guidance on topic selection, methodological and analytic expertise, and quality improvement science tools and methods expertise; performs technical interpretive writing; develops PIP templates and instructional guides for the health plans; conducts on-site meeting facilitation, webinar trainings (upcoming speaker at the 2018 National CMS Quality Conference); provides ongoing technical assistance for health plan and state staff, guides health plans through the transition to the rapid cycle PIP approach upon request by the state, and contributes to the EQRO technical report, as prescribed in 45 CFR §438.364***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Cypress College, Cypress, California, Associate of Science, Nursing, 1986

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Licensed Registered Nurse
Certified Professional in Healthcare Quality (CPHQ) by the Healthcare Quality Certification Board, 2009

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Rachel La Croix, Ph.D., PMP*** ***AHC Administrator, Performance Evaluation and Research Unit*** ***Bureau of Medicaid Quality***
Organization	***Agency for Health Care Administration***
Phone ***Fax***	***850.412.4670*** ***None***
Email	***Rachel.LaCroix@ahca.myflorida.com***
Reference #2	
Name ***Title***	***Danielle Culp, Quality Health Improvement Specialist*** ***Quality and Health Improvement Unit***
Organization	***Colorado Department of Health Care Policy and Financing***
Phone ***Fax***	***303.866.5897*** ***None***
Email	***Danielle.Culp@state.co.us***

Reference #3	
Name ***Title***	***Tom Curtis, Quality Manager*** ***Managed Care Plan Division, 7th Floor***
Organization	***Michigan Department of Health and Human Services***
Phone ***Fax***	***517.284.1149*** ***517.241.8231***
Email	***CurtisT2@michigan.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Amber Saldivar, MHSM, BS***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director, Data Science and Advanced Analytics***		
# of Years in Classification:	***11***	**# of Years with Firm:**	***13***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Saldivar has more than 13 years of experience in the healthcare industry with expertise in research, analysis, and reporting. She has extensive knowledge and experience with analyzing data at various organizational levels including analyses performed at the patient, provider, hospital, and nursing home levels. Ms. Saldivar has expertise in survey analytic activities, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®), quality of life, and provider surveys. She has assisted state Medicaid agencies with various external quality review (EQR) activities for over 11 years.

Ms. Saldivar has extensive experience working with Medicaid programs to analyze and evaluate aggregated information on timeliness, access, and quality of healthcare services furnished to Medicaid beneficiaries. She is responsible for the day-to-day oversight of the data management and analysis functions for several Medicaid EQR projects, involving the administration of thousands of annual surveys to adult Medicaid beneficiaries, child Medicaid beneficiaries, and/or children with chronic conditions on behalf of several state Medicaid agencies. Ms. Saldivar is also responsible for developing sound sampling and analytic methodologies to ensure survey results yield meaningful information.

As part of the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Initiative (FAI) Support contract to integrate care for dual eligible individuals, Ms. Saldivar managed the development of performance measures for the capitated and managed fee-for-service (MFFS) models so that states and CMS can monitor performance. Additionally, she oversees analytic activities on HSAG's Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contracts. Ms. Saldivar's team produces hospital-specific analyses and provides technical assistance to support QIN-QIO goals for Medicare beneficiaries such as improving beneficiary and family-centered care; reducing healthcare-associated infections, healthcare-acquired conditions, and adverse drug events; and improving prevention and early diagnosis.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***July 2006 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Director, Data Science and Advanced Analytics***

Contract / Project:	***State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy*** ***State of California Department of Health Care Services (EQRO contract)*** ***State of Colorado Department of Health Care Policy and Financing (EQRO contract)*** ***State of Hawaii Department of Human Services (ERQO contract)*** ***State of Ohio Department of Medicaid (ERQO contract)*** ***State of Arizona Healthcare Cost Containment System (EQRO contract)*** ***Centers for Medicare & Medicaid Services (QIN-QIO contract)***
Contract / Project Details:	***Oversees all Medicaid EQR survey responsibilities, including CAHPS and provider surveys; directs and oversees all Medicaid-targeted survey activities, including Medicaid managed care programs and CHIP programs, to analyze and evaluate aggregated information on timeliness, access, and quality of healthcare services furnished to Medicaid beneficiaries; provides technical assistance to states on CAHPS and provider survey activities, contributes to the EQRO technical report as prescribed in 45 CFR §438.364, oversees analytic activities on HSAG's QIN-QIO contracts; produces hospital-specific analyses and provides technical assistance to support QIN-QIO goals for Medicare beneficiaries, such as improving beneficiary and family-centered care, reducing healthcare-associated infections, healthcare-acquired conditions, and adverse drug events, and improving prevention and early diagnosis***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Master of Health Sector Management, 2005
Arizona State University, Tempe, Arizona, Bachelor of Science, Finance, 2003

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Mary Anne Butcher*** ***HSAG IDIQ, AZ, CA and OH Contracting Officer Representative*** ***Division of Quality Improvement Region X***
Organization	***Centers for Medicare & Medicaid Services***
Phone ***Fax***	***206.615.2376*** ***None***
Email	***Maryanne.butcher@cms.hhs.gov***

Reference #2	
Name ***Title***	***Russell Kennedy*** ***Quality and Compliance Specialist***
Organization	***Colorado Department of Healthcare Policy and Financing***
Phone ***Fax***	***303.866.3340*** ***None***
Email	***Russell.kennedy@state.co.us***
Reference #3	
Name ***Title***	***Tammy Simon*** ***Medicaid Health Systems Administrator***
Organization	***Ohio Department of Medicaid***
Phone ***Fax***	***614.752.4572*** ***None***
Email	***Tammy.simon@medicaid.ohio.gov***

Health Services Advisory Group, Inc. (HSAG)
Other Staff Resumes

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Leslie Arendell, MS, BA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Associate Director, Data Science and Advanced Analytics***		
# of Years in Classification:	***3.5***	**# of Years with Firm:**	***5.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Arendell has more than 15 years of experience working in epidemiological research and data analysis with expertise in study design, analysis planning, statistical analysis, and report writing. She has expertise and experience with Medicare and Medicaid programs and data systems. Ms. Arendell has substantial data management and data analysis experience, including work with large datasets. She is experienced in both written and verbal presentations to the scientific and non-scientific communities.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2014 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Associate Director, Data Science and Advanced Analytics***

Contract / Project:

State of Arkansas Division of Medical Services (Data Mining and Program Evaluation contract)

State of California Department of Health Care Services (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Tennessee Bureau of TennCare (EQR subcontract)

Contract / Project Details: ***Prepares methodologies and analytic plans for network adequacy assessments, focused studies and data mining projects; leads analytic projects, including methodology preparation, planning and conducting data analysis, analytic validation, deliverable preparation and staff supervision***

Timeframe:	***June 2012 to October 2014***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Associate Director, Research and Analysis Team***
Contract / Project:	***CMS Measures Impact Assessment***
Contract / Project Details:	***Led team of analysts responsible for conducting analyses for triennial CMS assessment of the impact of quality and efficiency measures; maintained up-to-date knowledge and understanding of all data types to support quality measures; maintained proficiency in complex statistical and data analytic issues related to measure development, implementation, and maintenance; provided collegial leadership on the team and provides timely and responsive support to CMS, CMS-measure contractors, and other organizations when necessary; evaluated quality measures with statistical calculations and maintains up-to-date knowledge on various statistical issues and statistical programming methodology related to quality measurement***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Tucson, Arizona, Master of Science, Epidemiology, 2001
Wittenberg University, Springfield, Ohio, Bachelor of Arts, Biology and Spanish, 1999

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Anna Lee Amarnath, MD, MPH*** ***Medical Program Consultant & Section Chief*** ***Medi-Cal Managed Care***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5015*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***
Reference #2	
Name ***Title***	***Gina Redford*** ***Manager, Analytic Services***
Organization	***AFMC***
Phone ***Fax***	***501.212.8722*** ***None***
Email	***Gina.Redford@afmc.org***

Reference #3	
Name ***Title***	***Mark Plunkett, PhD*** ***Senior Analyst***
Organization	***American Hospital Association***
Phone ***Fax***	***602.319.8835*** ***None***
Email	***mplunkett@aha.org***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Alana Berrett, MPH, BA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Associate Director, Data Science and Advanced Analytics***		
# of Years in Classification:	***6***	**# of Years with Firm:**	***6***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

With more than 13 years of healthcare and public health industry experience, Ms. Berrett is an experienced epidemiologist and statistical analyst, with expertise in managing and coordinating analytical work in support of external quality review activities, as well as the cleaning and analysis of large datasets using SAS.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***December 2011 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Associate Director, Data Science and Advanced Analytics***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of Arkansas Department of Medicaid Services (Data Mining and Program Evaluation contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Michigan Department of Health & Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Bureau of TennCare (EQR subcontract)

	Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)
Contract / Project Details:	***Supports EQRO and EQR-like contracts with state Medicaid agencies by successfully designing and conducting focused studies, encounter data validation studies, and network adequacy assessments, including staff supervision, deliverable preparation, and customer communications***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Tucson, Arizona, Master of Public Health, Epidemiology, 2006
Washington University in St. Louis, St. Louis, Missouri, Bachelor of Arts, History, 2004

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Jerry Ware*** ***Quality and Compliance Specialist*** ***Quality and Health Improvement Unit***
Organization	***Colorado Department of Health Care Policy and Financing***
Phone ***Fax***	***303.866.2335*** ***None***
Email	***Jerry.Ware@state.co.us***
Reference #2	
Name ***Title***	***Valerie Collier*** ***Quality Program Manager*** ***Division of Health Care Services***
Organization	***Virginia Department of Medical Assistance Services***
Phone ***Fax***	***804.786.2273*** ***None***
Email	***Valerie.Collier@dmas.virginia.gov***
Reference #3	
Name ***Title***	***Anna Lee Amarnath, MD, MPH*** ***Medical Program Consultant & Section Chief*** ***Medi-Cal Managed Care***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5039*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Eliza Buyong, MS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Healthcare Analyst III, Data Science and Advanced Analytics***		
# of Years in Classification:	***13.5***	**# of Years with Firm:**	***13.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Buyong has more than 20 years of experience in the healthcare industry as a healthcare analyst and educator, with expertise in education, data analysis, and report generation using Statistical Analysis Systems (SAS). Ms. Buyong worked as a healthcare analyst for the Pennsylvania Health Care Cost Containment Council developing and implementing statistical methodology and models for various council studies. Prior to her healthcare industry roles, she served as a secondary education-level educator in the disciplines of mathematics and statistics. Fluent in algebra, calculus, and other forms of advanced mathematics, Ms. Buyong structured course curricula for engineers, business students, and students of the health sciences.

As a healthcare analyst and SAS programmer at Health Services Advisory Group, Inc., Ms. Buyong is responsible for data management, development of study methodology, conducting accurate and verified descriptive and statistical analysis of patterns of care and outcomes, validating results from other analysts, interpreting study results, and preparing reports for dissemination and presentations. She conducts literature searches/reviews, designs statistical analysis plans, and defines case selection criteria and variable parameters. She has also conducted various analyses using Healthcare Effectiveness Data and Information Set (HEDIS®) data files, and worked on several telephone survey and various data mining projects.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe:	***July 2003 to Present***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Healthcare Analyst III, Data Science and Advanced Analytics***
Contract / Project:	***State of Nevada Department of Health and Human Services Division of Health Care Financing and Policy (EQRO contract)***
	State of Arkansas Department of Medicaid Services (Data Mining and Program Evaluation contract)
	State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Michigan Department of Health & Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Conducts encounter data validation studies associated with several of the state contracts listed above; successfully completes encounter data validation-related tasks: develops study methodology; prepares data submission requirements documents; performs administrative profile analysis; performs comparative analysis among state's, MCOs', and PBMs' data; prepares sample cases for medical record review procurement; assists with electronic tool design; performs analysis on abstracted data; conducts on-site audit and desk reviews of discrepant sample cases; provides technical assistance to the health plans; summarizes study findings and recommendations into a report; supports several of the EQRO contracts listed above for various other activities, including focused studies and network adequacy assessments***

Timeframe: ***1998 to 2004***
Company Name: ***Pennsylvania Health Care Cost Containment Council***
Company Location: ***Harrisburg, Pennsylvania***
Position Title: ***Statistical Analyst***
Contract / Project: ***C-Section Deliveries in Pennsylvania and Hospital Performance***

Contract / Project Details: ***Developed and implemented statistical methodology for complex research and evaluation studies; reviewed risk adjustment methodology for outcomes reporting; performed statistical analysis; made recommendations pertaining to study design and clinical issues; and assisted in interpreting key findings for council's flagship public and commissioned reports; performed statistical analysis on administrative hospital discharge data to review data quality; identifying problems and making recommendations for resolutions.***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Bowling Green State University, Bowling Green, Ohio, Master of Science, Applied Statistics, 1985
Northern Illinois University, DeKalb, Illinois, Bachelor of Science, Mathematics, 1983

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*	
Reference #1	
Name *Title*	*Rachel M. La Croix, Ph.D., PMP* *AHC Administrator, Performance Evaluation and Research Unit* *Bureau of Medicaid Quality*
Organization	*Florida Agency for Health Care Administration*
Phone *Fax*	*850.412.4670* *None*
Email	*Rachel.LaCroix@ahca.myflorida.com*
Reference #2	
Name *Title*	*Flossie Wolf* *Director, Health Policy Research*
Organization	*PA Health Care Cost Containment Council, Commonwealth of Pennsylvania*
Phone *Fax*	*717.232.6787* *717.232.3821*
Email	*fwolf@phc4.org*
Reference #3	
Name *Title*	*Judy Yip, Ph.D.* *Institutional Research Analyst*
Organization	*Northland Pioneer College*
Phone *Fax*	*605.509.3026* *None*
Email	*dmctyl@yahoo.com*

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Debra L. Chotkevys, DHA, MBA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Executive Director, State and Corporate Services***		
# of Years in Classification:	***18***	**# of Years with Firm:**	***14.4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Dr. Chotkevys has more than 30 years of healthcare industry experience, with expertise in compliance activities, hospital administration, physician services, marketing, credentialing, office site reviews, Healthcare Effectiveness Data and Information Set (HEDIS®) audits, medical record abstraction, and accreditation standards. She has been involved in external quality reviews (EQRs) for Medicaid managed care for the past 18 years, reviewing quality and operational standards and performing project management.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***October 2003 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Executive Director***

Contract / Project:

State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Georgia Department of Community Health (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Vermont Agency of Human Services (EQRO contract)

State of Tennessee Bureau of TennCare (EQRO subcontractor)

Contract / Project Details: ***Provides leadership and overall project management for EQR services for the Vermont, New Hampshire, and Tennessee contracts;***

participates in annual on-site reviews of health plans; instrumental in the design and development of focused studies performed by HSAG and works to ensure completion of EQR projects, as required by established timelines; coordinates with HSAG healthcare analysts to ensure interpretations of focused studies include state-specific information; attends meetings with states, MCOs, and stakeholders to present findings from focused studies, administrative reviews, case management program reviews, encounter data studies, focused studies, consumer satisfaction survey results, and performance measures; conducts frequent telephonic meetings with states to coordinate EQR tasks conducted by HSAG teams; performs compliance reviews, MCO readiness reviews, case management system reviews, and call center reviews; provides numerous hours of technical assistance to the MCOs and state staff members

Timeframe:	***January 2000 to October 2003***
Company Name:	***Delmarva Foundation for Medical Care, Inc.***
Company Location:	***Easton, Maryland***
Position Title:	***Director***
Contract / Project:	***State of Ohio (EQRO Contract)*** ***State of Michigan (EQRO Contract)*** ***State of West Virginia (EQRO Contract)***
Contract / Project Details:	***Responsible for the overall operations of the EQR contract for three states; worked with the states, MCOs, and providers to assess and monitor care delivered to the Medicaid population; conducted medical record abstraction for quality studies, performed on-site reviews at the MCOs, and provided technical assistance to MCOs and state Medicaid bureaus; projects included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts and federal requirements during annual on-site audits; assisted in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, and credentialing; designed and developed quality studies to monitor care; worked with scientists, physicians, and health analysts to interpret data; researched current literature and wrote reports for quality studies; presented findings to state committees and MCO representatives; for the Easton, Maryland office, prepared responses to requests for proposals for new business opportunities at the state, regional, and national levels with various state agencies and the Centers for Medicare & Medicaid Services (CMS); revised credentialing system for Delmarva's network of physicians and allied health***

Timeframe:	***1993–1999***
Company Name:	***Aperture Credentialing, Inc.***
Company Location:	***Louisville, Kentucky***
Position Title:	***Director***
Contract / Project:	***Provider Credentialing, Office Site Reviews, and Medical Record Abstractions***
Contract / Project Details:	***Responsible for the management of projects involving physician credentialing, physician office site reviews, and medical record abstractions; daily tasks included 1) hiring and training registered nurses nationwide to assist in credentialing activities, HEDIS audits,***

and quality studies for MCOs; 2) utilizing a centralized scheduling team concept to schedule nurse reviewers for provider on-site surveys; 3) developing, implementing, and maintaining quality standards; 4) assisting with sales activities to generate new business; and 5) performing delegated audits according to NCQA, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the URAC standards

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Phoenix, Phoenix, Arizona, Doctor of Health Administration, 2009
Baldwin–Wallace College, Berea, Ohio, Master of Business Administration, 1977
Wittenberg University, Springfield, Ohio, Bachelor of Music, 1970

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

None

REFERENCES
A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Shawn E. Skaflestad, PhD*** ***Quality Improvement Manager***
Organization	***Vermont Agency of Human Services***
Phone ***Fax***	***802.241.0961*** ***802.241.0450***
Email	***Shawn.Skaflestad@vermont.gov***
Reference #2	
Name ***Title***	***Lisa Horn, MILR*** ***President***
Organization	***Horn Research LLC***
Phone ***Fax***	***607.316.2748*** ***888.316.1851***
Email	***lisa@hornresearch.com***
Reference #3	
Name ***Title***	***John Couzins, MPH, CHCA*** ***EQRO Director***
Organization	***Qsource***
Phone ***Fax***	***866.514.8595*** ***615.244.2018***
Email	***jcouzins@Qsource.org***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Cheena David, BS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Healthcare Analyst 1, Data Science and Advanced Analytics***		
# of Years in Classification:	***5***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. David has more than five years of experience in the healthcare industry with extensive expertise in analytics and creative thinking, which she applies to support project management activities for informatics projects. She supports data activities by conducting and interpreting primary analyses, conducting secondary and exploratory analyses, and performing data validation for 10 state Medicaid agencies' Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and survey-related projects. Additionally, Ms. David is responsible for generating results on characteristics, operations, trends, and types of providers that Patient Safety Organizations (PSOs) serve, as stated in their PSO profile.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2015 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Healthcare Analyst 1***

Contract / Project:

State of Arizona Health Care Cost Containment System (AHCCCS) (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (DMAS) (EQRO contract)

	Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative
Contract / Project Details:	***Responsible for analytic survey activities for multiple states by evaluating CAHPS and survey data in calculating measure rates using standardized specifications; performs data analysis on PSO profile in determining the characteristics and trends of each PSOs; assesses patient safety event data to attain findings as part of strategic quality improvement***
Timeframe:	***April 2015 to October 2015***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Analytic Specialist***
Contract / Project:	***State of Arizona AHCCCS (EQRO contract)***
	State of Illinois Department of Healthcare and Family Services (EQRO contract)
	State of New Hampshire Department of Health and Human Services (EQRO contract)
	Commonwealth of Virginia DMAS (EQRO contract)
	AHRQ-PSOPPC contract
Contract / Project Details:	***Performed analytic validation and ad hoc analyses for survey activities for multiple states; assisted lead analysts in validating, cleaning, and analyzing survey data***
Timeframe:	***July 2013 to April 2015***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Administrative Assistant***
Contract / Project:	***State of Arizona AHCCCS (EQRO contract)***
	State of Colorado Department of Health Care Policy & Financing (EQRO contract)
	State of Illinois Department of Healthcare and Family Services (EQRO contract)
	State of New Hampshire Department of Health and Human Services (EQRO contract)
	State of Washington Department of Social and Health Services Medical Assistance Administration (EQR services subcontract)
Contract / Project Details:	***Created survey data reports for monitoring survey data collection process and assisted in analytic validation, using healthcare specifications in calculating measure rates; performed overall project management and updates to deliverable information in databases; coordinated meetings; scheduled conferences; and performed report validation***
Timeframe:	***November 2012 to June 2013***
Company Name:	***Health Services Advisory Group, Inc.***

Company Location:	***Phoenix, Arizona***
Position Title:	***Administrative Support Specialist***
Contract / Project:	***State of Arizona AHCCCS (EQRO contract)***
	State of Colorado Department of Health Care Policy & Financing (EQRO contract)
	State of Illinois Department of Healthcare and Family Services (EQRO contract)
	State of New Hampshire Department of Health and Human Services (EQRO contract)
	State of Washington Department of Social and Health Services Medical Assistance Administration (EQR services subcontract)
Contract / Project Details:	***Performed overall project management and daily updates to deliverable information in database; coordinated meetings; scheduled conferences; validated internal and external reports; provided project support to several informatics projects***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Santo Tomas, Manila, Philippines, Bachelor of Science, Business Administration–Business Economics, 2012

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Raymond Berens*** ***Associate Director***
Organization	***Health Services Advisory Group, Inc.***
Phone ***Fax***	***602.801.6828*** ***602.801.6051***
Email	***rberens@hsag.com***
Reference #2	
Name ***Title***	***Amber Saldivar*** ***Director***
Organization	***Health Services Advisory Group, Inc.***
Phone ***Fax***	***602.801.6822*** ***602.801.6051***
Email	***asaldivar@hsag.com***
Reference #3	
Name ***Title***	***Jiaju Liu*** ***Analyst 2***
Organization	***Health Services Advisory Group, Inc.***
Phone ***Fax***	***602.801.6882*** ***602.801.6051***
Email	***jliu@hsag.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc. (HSAG)***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jade Dietzman, BS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Project Support Specialist, Data Science and Advanced Analytics***		
# of Years in Classification:	***<1***	**# of Years with Firm:**	***<1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Dietzman has 10 years of experience in providing administrative and project support, with expertise in developing and facilitating internal department procedures, researching and analyzing data, and medical terminology.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2017 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Project Support Specialist, DSAA***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO) contract)

State of California Department of Health Care Services (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Tennessee Bureau of TennCare (EQR services subcontract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Assists project staff with coordination of daily project activities; provides project support through project updates; performs report population and validation; performs medical record tracking, secret shopping, and reveal shopper survey calls; performs deliverable preparation***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Phoenix, Arizona, Bachelor of Science, Psychology, 2015
Grand Canyon University, Phoenix, Arizona, master's studies in healthcare management, (in-progress)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name *Title*	***Cecilia Mendoza-Henshaw*** ***Business Manager***
Organization	***Oasis Discovery Partners***
Phone *Fax*	***480.620.9833*** ***None***
Email	***cmh@oasisdiscovery.com***
Reference #2	
Name *Title*	***Megan Koren*** ***Finance Director***
Organization	***Cresa Global, Inc.***
Phone *Fax*	***760.586.9677*** ***None***
Email	***mkoren@cresa.com***
Reference #3	
Name *Title*	***Shannon Reed*** ***Principal Consultant***
Organization	***CommonSource***
Phone *Fax*	***713.824.7192*** ***None***
Email	***shannon@commonsource.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Kim M. Elliott, PhD, CPHQ, CHCA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Executive Director, HEDIS and Performance Measures (PM) Audits Team, State and Corporate Services***		
# of Years in Classification:	***25***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Dr. Elliott has more than 25 years of experience in the healthcare industry, with expertise that spans organizational management, stakeholder relationship development, systems improvements, audits and surveys, quality management, and performance improvements. She is a national and local speaker on quality, maternal and child health, and intersection of quality and program integrity topics. Dr. Elliott has advanced knowledge of managed care programs, as well as commercial, Medicaid, and Medicare products.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Executive Director, HEDIS and PM Audits***

Contract / Project:

State EQRO contracts

CMS Financial Alignment Initiative contract

CMS Medicare VBP4P contracts

Private HEDIS contracts

URAC Pharmacy Organization Data Validation contracts

State of Georgia (EQRO contract)

Contract / Project Details: ***Directs the HEDIS and PM Audits Team for HSAG's external quality review organization (EQRO) contracts in various states; coordinates internal and external resources to achieve goals and objectives of the contracts; responsible for accurate and timely completion of activities and deliverables; applies NCQA requirements, as well as state and federal Medicaid managed care regulations to daily activities; provides overall management of audit projects, budgets, and financial oversight; directs medical record review and audit processes for***

validation of Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Core Measure sets, and state-specific performance measures; analyzes data, measures project progress against project requirements, objectives, and success criteria; makes recommendations and develops strategies and solutions; serves as director of state EQRO contracts

Timeframe:	***March 2016 to December 2016***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Director, State and Corporate Services***
Contract / Project:	***State of Iowa Department of Human Services (EQRO contract)*** ***State of Michigan (EQRO behavioral health contract)*** ***State of Michigan (EQRO physical health contract)*** ***State of Georgia Department of Community Health (EQRO contract)***
Contract / Project Details:	***Provided oversight of EQRO contracts in various states and coordinated internal and external resources to achieve contract goals and objectives; provided oversight throughout all stages of the contracts, including responding to RFPs, project initiation, recruitment selection, orientation, training, staff supervision, customer relations, project planning and budgeting, completion of field work, and report preparation and finalization; accountable for state and subcontract communications, staffing, and completion of all contracted EQRO activities; provided technical assistance to state Medicaid and managed care plan staff members related to all EQR activities and provided actionable recommendations, when applicable, on quality improvement strategies***

Timeframe:	***July 2001 to March 2016***
Company Name:	***Arizona Health Care Cost Containment System (AHCCCS)***
Company Location:	***Phoenix, Arizona***
Position Title:	***Administrator, Clinical Quality Management***
Contract / Project:	***Medicaid and CHIP Program Key Staff Position***
Contract / Project Details:	***Led the Clinical Quality Management team (34 professional and non-professional staff) comprising quality management and quality improvement; maternal and child health/early, periodic, screening, diagnostic and treatment (EPSDT); behavioral health quality, and electronic health record incentive project teams for the Medicaid and CHIP Program (AHCCCS) in Arizona; led quality and clinical efforts related to acute, long-term care, special needs, behavioral health, foster children, and developmentally disabled populations; assumed leadership in the development and implementation of the State's quality strategy in compliance with the Centers for Medicare and Medicare Services (CMS) requirements, and in alignment with the Agency's strategic plan focused on improving quality of care, member and provider satisfaction, cost effectiveness, and administrative efficiency; led federal, State, and legislative reporting related to quality activities and performance metrics; led the quality management, quality improvement, and maternal and child health teams, as well as the Medical Management area, to maintain clinical policies according to the standard of care and in compliance with federal and State requirements, and in accordance with the Arizona***

Waiver and the Arizona State Plan; recommended and led the transition of quality and performance metrics from a process driven set, to outcomes measures that include measures required by CMS, those required to evaluate the effectiveness of program integration and measures that are meaningful to all lines of business in the Medicaid program; led the development and implementation of performance improvement projects that resulted in improved care, outcomes, administrative, and cost efficiencies; developed and implemented a quality management program that focused on individual and systemic issues, improved care and services throughout the system of care, addressed care needed today and challenging member needs, and improved processes for health and safety in emergency situations; developed the first medical management/utilization management policies for the AHCCCS managed care program; represented the Agency at the federal, State, and local level, including work with community organizations, other State agencies, federal programs, and stakeholder groups with a focus on aligning and achieving positive outcomes in a win-win environment; served on federal subject matter expert panels including those focused on CMS Core Measure sets, access to care, upper respiratory and critical care and long-term care

Timeframe:	***June 1999 to July 2001***
Company Name:	***Arizona Physicians IPA (A United Healthcare company)***
Company Location:	***Phoenix, Arizona***
Position Title:	***Director, Prevention and Wellness***
Contract / Project:	***Medicaid and CHIP managed care contract with AHCCCS***
Contract / Project Details:	***Responsible for meeting State and federal requirements for an acute care, long-term care, and developmentally disabled population; provided leadership, direction, and management of the quality management, prevention and wellness, maternal and child health, and behavioral health programs for the acute, long-term care, developmentally disabled, CHIP healthcare group, and children with special healthcare needs (CSHCN) programs; developed, managed, and implemented quality metrics including HEDIS quality measures, Medicaid measures, audits, studies, and report cards; co-led the National Committee for Quality Assurance (NCQA) accreditation process and was responsible for annual HEDIS audits; developed and implemented care coordination and disease management programs for chronic conditions including diabetes, asthma, hypertension, and congestive heart failure; led quality review, peer review, and compliance review teams to meet federal/state requirements, and was selected by United Corporate to train United Healthcare Medicaid program staff nationwide on the development and implementation of preventive health programs, outreach programs, EPSDT requirements, and the development of corrective actions plans***
Timeframe:	***September 1985 to May 1999***
Company Name:	***CIGNA Health Care***
Company Location:	***Phoenix, Arizona***
Position Title:	***Provider Relations and Contracting Representative***
Contract / Project:	***Commercial, Medicare, and Medicaid contracts***
Contract / Project Details:	***Responsible for developing and growing a successful provider relations and contracting area in a new private practice model for a***

traditionally facility-based (staff model) managed care organization; successfully expanded provider network state-wide through negotiations with non-managed care providers, and participated in a team to develop and implement some of the first value-based or pay-for-performance based payment models; developed and implemented provider report or score cards focusing on areas of opportunities in utilization management by wellness or disease state

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Honolulu University, Honolulu, Hawaii, Doctor of Philosophy, Health Sciences, Emphasis in Preventive Health, 2001

University of Phoenix, Phoenix, Arizona, Master of Arts, Organizational Management, 1988

University of Phoenix, Phoenix, Arizona, Bachelor of Science, Business Administration, 1986

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified HEDIS Compliance Auditor (CHCA), 2017
Certified Professional in Health Care Quality, National Association of Health Care Quality, 1999
Certification in the Science of Improvement, Quality Improvement and Patient Safety, Institute for Healthcare Improvement, Open School, 2016

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name Title	Marc Leib, M.D., J.D. Anesthesiologist/Consultant Medical Director
Organization	Consultant, former Chief Medical Officer AHCCCS
Phone Fax	602.708.8455 None
Email	mlleib@att.net
Reference #2	
Name Title	Albena Baharieva, M.D. Internal Medicine/Consultant Medical Director
Organization	Private Consultant, Medicaid, Medicare, and Commercial
Phone Fax	602.350.0460 None
Email	albenabah@gmail.com
Reference #3	
Name Title	Peggy Stemmler, M.D. Pediatrician/Consultant
Organization	Frameshift Group
Phone Fax	602.909.2991 None
Email	peggy@frameshiftgroup.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Nicole Fair, MS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analytics Manager, Data Science and Advanced Analytics***		
# of Years in Classification:	***4***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Fair has more than eight years of administrative, project coordination, and project management experience with expertise in technical and professional writing. She conducts extensive reviews of all deliverables prior to submission to customers to ensure quality and timely products.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***February 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analytics Manager***

Contract / Project:

State of Nevada Division of Health Care Financing an Policy (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Supports performance measure calculation activities through defining measure specifications, assisting with measure selection, developing data requests, collecting data, and extensively reviewing deliverables for the states of Nevada, Iowa, and Virginia; performs technical writing activities for Ohio EQRO contract, including constructing, writing, and extensively reviewing and validating reports and documents; manages development and production of***

Quality Rating Systems (QRSs) for several states, including Illinois, Iowa, Michigan, Ohio, and Virginia; responsibilities include data collection, methodology development, template development, deliverable preparation, and presentation of results to stakeholders; assists with performance measure calculation activities, data collection, measure specification development, and reporting

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Grand Canyon University, Phoenix, Arizona, Masters of Science, Healthcare Administration, 2017
Syracuse University, Syracuse, New York, Bachelor of Science, Biology, and Writing and Rhetoric, 2013

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name *Title*	***Jason Holst*** ***Quality Improvement Analyst***
Organization	***Iowa Department of Human Services***
Phone *Fax*	***515.974.3070*** ***None***
Email	***jholst@dhs.state.ia.us***
Reference #2	
Name *Title*	***Latanya Crawford*** ***Managed Care Quality Analyst***
Organization	***Virginia Department of Medical Assistance and Services***
Phone *Fax*	***804.593.2459*** ***None***
Email	***Latanya.crawford@dmas.virginia.gov***
Reference #3	
Name *Title*	***Mark Rizzutti*** ***Analytics Manager***
Organization	***Ohio Department of Medicaid***
Phone *Fax*	***614.752.4592*** ***None***
Email	***Mark.Rizzutti@medicaid.ohio.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Tammy GianFrancisco***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***HEDIS Manager, State and Corporate Services***		
# of Years in Classification:	***15***	**# of Years with Firm:**	***15***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. GianFrancisco has more than 15 years of experience in the healthcare industry with expertise in project management, coordination of the Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure validation (PMV), and pay-for-performance (PfP) audit activities throughout all stages of the process.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***June 2014 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***HEDIS Manager, State and Corporate Audits Team***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Hawaii Department of Human Services, Med-QUEST Division (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

Georgia Department of Community Health (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Iowa Department of Health Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

	State of New Hampshire Department of Health and Human Services (EQRO contract) ***State of Tennessee Bureau of TennCare (EQR services, subcontract)*** ***State of Utah Department of Health (EQRO contract)*** ***Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)*** ***State of Vermont Agency of Human Services (EQRO contract)*** ***HEDIS Compliance Audits*** ***Value-Based Pay for Performance Audit Reviews*** ***CMS Medicare Part C and Part D Data Validation Audits*** ***Validation of Performance Measure Audits***
Contract / Project Details:	***Assists the director with oversight of the day-to-day operations of audit activities, including HEDIS and Performance Measure Validation (PMV) audits for state and private customers, value-based pay for performance (VBP4P), and CMS Medicare Part C and Part D data validation audits for private customers; manages timelines for all aspects of audit activities; assists with contract preparation and proposals; manages source code review activities; prepares audit-related documentation and tools, report writing, and validation; manages rate review activities and final audit report production for HEDIS and VBP4P audits; responsible for project planning and meeting project timelines and deliverables***
Timeframe:	***March 2003 to June 2014***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Project Leader, Audits/State and Corporate Services***
Contract / Project:	***State of Nevada Division of Health Care Financing and Policy (EQRO contract)*** ***California Department of Health Care Services (EQRO contract)*** ***State of Colorado Department of Health Care Policy and Financing (EQRO contract)*** ***State of Florida Agency for Health Care Administration (EQRO contract)*** ***State of Georgia Department of Community Health (EQRO contract)*** ***State of Hawaii Department of Human Services (EQRO contract)*** ***State of Illinois Department of Healthcare and Family Services (EQRO contract)*** ***State of Michigan Department of Health and Human Services (EQRO contract)*** ***State of New Hampshire Department of Health and Human Services (EQRO contract)*** ***State of Tennessee Bureau of TennCare (EQR services, subcontract)*** ***State of Utah Department of Health (EQRO contract)***

State of Vermont Agency of Human Services (EQRO contract)
Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

HEDIS Compliance Audits

Value-Based Pay for Performance Audit Reviews

CMS Medicare Part C and Part D Data Validation Audits

Validation of Performance Measure Audits

Contract / Project Details: ***Coordinated and participated in audit activities in all stages of the process for private contracts and state external quality review organization (EQRO) contracts; drafted audit correspondence; managed the audit schedule; supported process development; managed source code review process for the PMV, HEDIS, and VBP4P audit activities, ensuring use of accurate specifications; monitored completion of all audit activities; developed and adhered to project timelines; ensured state, plan-specific, and National Committee for Quality Assurance guidelines were met, when applicable; updated executive directors for state EQRO contracts on the progress of audit activities, and developed and maintained audit contact lists at the state and plan levels; assisted the performance improvement project (PIP) team with validation of reported HEDIS and PMV rates to help ensure accuracy and to determine discrepancies with PIP rate submissions; provided technical and audit assistance to state audit clients, health plans, and internal departments; provided administrative support to the audit team***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

None

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Wendy Talbot, MPH, CHCA*** ***Director, Measure Validation***
Organization	***National Committee of Quality Assurance***
Phone ***Fax***	***202.955.1708*** ***None***
Email	***talbot@ncqa.org***
Reference #2	
Name ***Title***	***Patience Hoag, RHIT, CHCA, CHDA, CCS, CCS-P, CPHQ*** ***Director of Audits and Special Projects***
Organization	***Aqurate Health Data, Inc.***
Phone ***Fax***	***602.614.0996*** ***None***
Email	***phoag@aguratedata.com***

Reference #3	
Name ***Title***	***Jennifer Lenz, MPH, CHCA*** ***President***
Organization	***QRS, LLC***
Phone ***Fax***	***480.438.1886*** ***None***
Email	***jlenz@qrs.email***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Mariana Grass, MPH, BBS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analytics Coordinator, Data Sciences and Advanced Analytics***		
# of Years in Classification:	***2.5***	**# of Years with Firm:**	***2.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Grass has more than eleven years of experience in the healthcare industry, with expertise in statistical analyses, quality analysis and reporting, and healthcare laboratory operations.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analytics Coordinator***

Contract / Project: ***State of Arizona Health Care Cost Containment System (EQRO contract)***

Colorado Department of Health Care Policy and Financing (EQRO contract)

Iowa Department of Human Services (EQRO contract)

Contract / Project Details: ***Assists states with performance measure calculation activities, including assistance with the review and selection of performance measures, data collection, data validation, performance measure calculation, rate reviews, deliverable preparation, and presentation of results to stakeholders***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

A.T. Still University, School of Health Management, Kirksville, Missouri, Master of Public Health, Education Research focus, 2011
Midwestern University, Glendale, Arizona, Bachelor of Biomedical Sciences, College of Health Sciences, 2006

CERTIFICATIONS *Information required should include: type of certification and date completed/received.*

None

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*

Reference #1	
Name *Title*	*Curt Curnow* *Quality and Health Improvement Section Manager*
Organization	*Colorado Health Care Policy and Financing*
Phone *Fax*	*303.866.5879* *303.866.5879*
Email	*Curt.Curnow@state.co.us*
Reference #2	
Name *Title*	*Dawn Sica* *Quality Improvement Coordinator*
Organization	*Arizona Health Care Cost Containment System Administration*
Phone *Fax*	*602.417.4823* *602.417.4855*
Email	*Dawn.Sica@azahcccs.gov*
Reference #3	
Name *Title*	*Jamie Robin* *Quality Improvement Manager*
Organization	*Arizona Health Care Cost Containment System Administration*
Phone *Fax*	*602.417.4717* *602.417.4855*
Email	*Jamie.Robin@azahcccs.gov*

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Donald Grostic, MS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Associate Director, Performance Improvement Project Methodologies***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***12***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Mr. Grostic has 25 years of experience in the healthcare industry with expertise in quality improvement, data analysis, statistical reporting, and database management in the managed care environment and expertise in quality of care studies, utilization analysis and reporting, and Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***January 2006 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Associate Director, Performance Improvement Projects Methodologies (PIPs)***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Georgia Department of Community Health (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Utah Department of Health (EQRO contract)

State of Vermont Agency of Human Services (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Successfully conducts performance improvement project implementation and validation activities; provides analytic expertise and research leadership for the PIP Team; responsible for providing analytic expertise and technical interpretive writing; ensuring the scientific soundness of study design, analysis, and interpretations of a variety of healthcare studies; serves as an internal and external liaison for PIP validation and analytic activities by planning, executing, and monitoring projects, managing customer relations, and providing technical assistance to state external quality review customers and health plans; provides analytical expertise for quality improvement projects utilizing several quality improvement tools including key driver diagrams, failure modes and effects analysis, run charts, and control charts through on-site meeting facilitation, webinar trainings and conference calls***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Vermont, Burlington, Vermont, Master of Science, Biostatistics, 1993
University of Vermont, Burlington, Vermont, Bachelor of Science, Mathematics, 1991

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified in the Institute for Healthcare Improvement (IHI) quality improvement science techniques, IHI Open School, 2017

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Rachel La Croix, Ph.D., PMP*** ***AHC Administrator, Performance Evaluation and Research Unit*** ***Bureau of Medicaid Quality***
Organization	***Agency for Health Care Administration***
Phone ***Fax***	***850.412.4670*** ***None***
Email	***Rachel.LaCroix@ahca.myflorida.com***
Reference #2	
Name ***Title***	***Anna Lee Amarnath*** ***Chief Medical Quality and Oversight***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5039*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***

Reference #3	
Name ***Title***	***Debra L. Chotkevys, DHA, MBA*** ***Executive Director, Professional Services***
Organization	***Health Services Advisory Group, Inc.***
Phone ***Fax***	***614.477.1563*** ***None***
Email	***dchotkevys@hsag.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Lacey Hinton, AASN, RN***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analytics Manager I, Data Science and Advanced Analytics***		
# of Years in Classification:	***4.5***	**# of Years with Firm:**	***6***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Hinton has more than six years of experience in the healthcare industry managing, coordinating, and supporting analytic and project activities, as well as working in the clinical nurse setting. She is experienced with Medicaid and external quality review organizations (EQROs). Ms. Hinton applies management skills to support Medicaid and EQRO work activities for senior leadership and project management staff.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***September 2013 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analytics Manager I***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Bureau of TennCare (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Provides project management support to internal project staff and external customers and/or subcontractors related to medical record procurement, encounter data validation, network adequacy, focused study activities; performs project management of secret shopper and revealed shopper surveys, medical record procurement, tracking, and abstraction processes, report population and validation, and deliverable preparation***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Estrella Mountain Community College, Avondale, Arizona, Associate in Applied Science in Nursing, 2010

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Licensed Registered Nurse, 2010

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Karen E Williamson*** ***Medical Records Quality Control Auditor***
Organization	***M. Davis and Company, Inc. (MDAC)***
Phone ***Fax***	***202.829.5973*** ***None***
Email	***karenw@mdavisco.com***
Reference #2	
Name ***Title***	***Anna Lee Amarnath*** ***Medical Program Consultant, Chief Medical Quality & Oversight Section*** ***Managed Care Quality and Monitoring Division***
Organization	***California Department of Health Care Services (DHCS)***
Phone ***Fax***	***916.449.5015*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***
Reference #3	
Name ***Title***	***Gina Redford*** ***Manager, Analytic Services***
Organization	***AFMC***
Phone ***Fax***	***501.212.8722*** ***None***
Email	***Gina.Redford@afmc.org***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Liwen (Laura) Jia, MS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Sr. Healthcare Analyst, Data Science and Advanced Analytics***		
# of Years in Classification:	***11***	**# of Years with Firm:**	***11***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Jia has more than 11 years of experience in the healthcare industry, with expertise in study design, statistics, data validation, application design and testing, and research analyses for patterns of care and focused studies. She is proficient in SAS and other statistical programs.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***October 2006 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Sr. Healthcare Analyst, Data Science and Advanced Analytics***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of Arkansas Department of Medicaid Services (Data Mining and Program Evaluation contract)

State of Arizona Department of Health Services (Case Review contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Georgia Department of Community Health (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

State of New Hampshire Office Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Division of TennCare (EQR subcontract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Supports EQRO and EQR-like contracts with state Medicaid agencies by successfully designing and conducting encounter data validation studies, focused studies, and network adequacy assessments, including staff supervision, deliverable preparation, and customer communications***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of North Carolina, Charlotte, North Carolina, Master of Science, Mathematics, 2005
University of Chicago, Chicago, Illinois, Master of Science, Chemistry, 2000
University of Science and Technology of China, Hefei, Anhui, China, Bachelor of Science, Chemical Physics, 1999

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Anna Lee Amarnath, MD, MPH*** ***Medical Program Consultant and Section Chief, Medi-Cal Managed Care***
Organization	***California Department of Health Care Services***
Phone ***Fax***	***916.449.5039*** ***None***
Email	***AnnaLee.Amarnath@dhcs.ca.gov***
Reference #2	
Name ***Title***	***Jason Holst*** ***Quality Improvement Analyst, Bureau of Managed Care Services and Supports***
Organization	***Iowa Department of Human Services***
Phone ***Fax***	***515.974.3070*** ***515.725.1360***
Email	***jholst@dhs.state.ia.us***

Reference #3	
Name ***Title***	***Judy Yip-Reyes, PhD*** ***Institutional Research Analyst***
Organization	***Northland Pioneer College***
Phone ***Fax***	***602.509.3026*** ***None***
Email	***dmctyl@yahoo.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Julia Lewis, BA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analytics Manager I, Data Science and Advanced Analytics***		
# of Years in Classification:	***4.4***	**# of Years with Firm:**	***4.4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Lewis has more than four years of experience in the healthcare industry providing project coordination and managerial activities, including research, schedule preparation, and communications with external customers, subcontractors, and project staff. She also has more than 11 years of administrative and customer service experience. Ms. Lewis presently manages the day-to-day analytic and project related activities for HSAG's external quality review organization (EQRO) contracts, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures reporting for several states.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***July 2017 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analytics Manager***

Contract / Project:

State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)

State of Arizona Health Care Cost Containment System (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Hawaii Department of Human Services, Med-QUEST Division (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Contract / Project Details:	***Assists with CAHPS Surveys and other survey administrations; day-to-day activities include coordination and management, appropriate and accurate reporting of results, establishing internal and external timelines, writing and validation of reports, and ensuring timely receipt of deliverables***
Timeframe:	***January 2015 to July 2017***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Analytics Coordinator***
Contract / Project:	***State of Arizona Health Care Cost Containment System (EQRO contract)*** ***State of California Department of Health Care Services (EQRO contract)*** ***State of Colorado Department of Health Care Policy & Financing (EQRO contract)*** ***State of Michigan Department of Health and Human Services (EQRO contract)*** ***State of Ohio Department of Medicaid (EQRO contract)***
Contract / Project Details:	***Assisted with CAHPS surveys and other survey administrations, along with HEDIS performance measures reporting; provided strong coordination and management skills, and appropriate and accurate reporting of results; established internal and external timelines; performed writing and validation of reports, and ensured timely receipt of deliverables***
Timeframe:	***November 2013 to January 2015***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Project Coordinator***
Contract / Project:	***Partnership for Patients (PfP)***
Contract / Project Details:	***Assisted with CAHPS Surveys and other survey administrations, along with HEDIS performance measures reporting; provided strong coordination skills, and appropriate and accurate reporting of results; established internal and external timelines; performed writing and validation of reports, and ensured timely receipt of deliverables***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

San Diego State University, San Diego, California, Bachelor of Arts, Sociology, 2013

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*	
Reference #1	
Name *Title*	*Paivi Beverly* *Departmental Technician*
Organization	*Michigan Department of Health and Human Services (MDHHS)*
Phone *Fax*	*517.284.1155* *None*
Email	*BeverlyP@michigan.gov*
Reference #2	
Name *Title*	*Russell Kennedy* *Quality and Compliance Specialist*
Organization	*Colorado Department of Health Care Policy & Financing (The Department)*
Phone *Fax*	*303.866.3340* *None*
Email	*russell.kennedy@state.co.us*
Reference #3	
Name *Title*	*Suzanne Turla* *Nurse Consultant*
Organization	*State of Hawaii Department of Human Services, Med-QUEST Division (The MQD)*
Phone *Fax*	*808.692.8110* *None*
Email	*sturla@dhs.hawaii.gov*

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jim (Jiaju) Liu, MS, BS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Informatics Analyst II, Data Science and Advanced Analytics***		
# of Years in Classification:	***2.4***	**# of Years with Firm:**	***2.7***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Mr. Liu's primary responsibilities include data analysis for nine state Medicaid agencies' Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and survey-related projects. He supports data activities by interpreting primary analyses, conducting secondary and exploratory analyses, and performing data validation. Mr. Liu's expertise spans statistical theory, computational statistics, project management, applied linear regression, multivariate analysis, categorical data analysis, and predictive modeling.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***July 2015 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analyst II***

Contract / Project:

State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy & Financing (EQRO contract)

State of Arizona Health Cost Containment System (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Conducts data analysis for CAHPS activities, including data validation, star rating calculation, statistical testing, data visualization***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Master of Science, Statistics, 2015
Southeast University, Nanjing, China, Bachelor of Science, Statistics, 2013

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name Title	Amber Saldivar Director
Organization	Health Services Advisory Group, Inc.
Phone Fax	602.801.6822 602.801.6051
Email	ASaldivar@hsag.com
Reference #2	
Name Title	Tim Laios Vice President & Chief Data Officer
Organization	Health Services Advisory Group, Inc.
Phone Fax	602.801.6810 602.801.6051
Email	TLaios@hsag.com
Reference #3	
Name Title	Kari Pikus Analytics Manager
Organization	Health Services Advisory Group, Inc.
Phone Fax	602.801.6817 602.801.6051
Email	KPikus@hsag.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Megan K. McLawhorn, MPH***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Informatics Analyst III, Data Science and Advanced Analytics***		
# of Years in Classification:	***2***	**# of Years with Firm:**	***3.6***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. McLawhorn has more than three years of healthcare industry experience in small- and large-scale data analysis for public health and healthcare related projects, and meets with customers to clearly understand the scope of their needs.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***February 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Informatics Analyst III***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Performs acquisition, validation, warehousing, and analysis of data, with focus on medical and prescription drug claims, as well as eligibility and enrollment data; develops and calculates CMS and state-specific measure specifications evaluating nursing facility utilization, along with Agency for Healthcare Research and Quality (AHRQ) pediatric and prevention quality indicators; calculates state performance measures based on NCQA HEDIS® specifications; compiles and automates reports for stakeholders on a routine basis that provide meaningful information to those who provide healthcare services to improve quality of care and health outcomes***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Tucson, Arizona, Master of Public Health, Epidemiology, 2014
University of Arizona, Tucson, Arizona, Bachelor of Science of Public Health, 2012

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name *Title*	*Mark Rizzutti* *Analytics Manager*
Organization	*Ohio Department of Medicaid*
Phone *Fax*	*614.752.4592* *None*
Email	*Mark.Rizzutti@medicaid.ohio.gov*
Reference #2	
Name *Title*	*Mike Steiner* *Value-Based Health Care Manager*
Organization	*Ohio Department of Medicaid*
Phone *Fax*	*614.752.3753* *None*
Email	*Michael.Steiner@medicaid.ohio.gov*
Reference #3	
Name *Title*	*Graham Briggs* *Assistant Director*
Organization	*Infectious Diseases and Epidemiology Section at Pinal County Public Health*
Phone *Fax*	*520.866.7325* *None*
Email	*Graham.Briggs@pinalcountyaz.gov*

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jennifer Montano***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Project Manager, State and Corporate Services***		
# of Years in Classification:	***27.7***	**# of Years with Firm:**	***27.7***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Montano has more than 27 years of experience in the healthcare industry with expertise in performance improvement projects (PIPs), administrative support and project coordination/ management, and expertise in the administration and coordination of federal and state contracts.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***June 2015 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Project Manager***

Contract / Project: ***State of Nevada Division of Health Care Financing and Policy (EQRO contract)***

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Tennessee Bureau of TennCare (EQR-related services)

Contract / Project Details: ***Provides day-to-day project management of the PIP team; maintains master database of PIP validation tools and provides technical support to health plans throughout their PIP process; assists in the editing and formatting of PIP validation tools and reports, and maintains several PIP tracking documents; serves as a liaison with health plans and state agencies to coordinate meetings, webinars, technical assistance calls and file transfer protocol (FTP) assistance; provides administrative support to all members of the PIP team as needed, including the executive directors for several external quality review organization (EQRO) contracts; responsible for compliance review database assistance, report production and formatting, FTP site maintenance, timeline monitoring, as well as meeting coordination, travel scheduling, and expense report processing***

Timeframe:	***1991 to 2015***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Project Coordinator, Administrative Assistant, Staff Secretary, Medical Records File Clerk***
Contract / Project:	***Various EQRO contracts*** ***Corporate Xerox contract*** ***QIO contract***
Contract / Project Details:	***Provided project coordination and administrative support to the executive director and the project director for external quality review organization (EQRO) contracts for Nevada, Florida, and Tennessee; responsible for compliance review database assistance, report production and formatting, file transfer protocol (FTP) site maintenance, timeline monitoring, as well as meeting coordination and travel scheduling; supported the corporate communications team, including creating, producing, and maintaining corporate marketing materials, business cards, and corporate stationary for all HSAG office locations; created and edited flyers, posters, ads, report covers and brochures; provided Federal Division administrative support to the director, health education and publications, director, health communications, as well as the communications project manager; maintained corporate Xerox Account; monitored and coordinated Xerox contract activities, including new equipment purchases, equipment updates, equipment moves, off-site production assistance, and staff coverage; responsible for monthly invoice reconciliation and account job coding for the production center in the Phoenix, Arizona location; assisted in production of several RFPs for state, federal, and private contracts***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

None

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Debra L. Chotkevys, DHA, MBA*** ***Executive Director, Professional Services***
Organization	***Health Services Advisory Group, Inc.***
Phone ***Fax***	***614.477.1563*** ***None***
Email	***dchotkevys@hsag.com***

Reference #2	
Name ***Title***	***Tina Crane*** ***Kindergarten Teacher***
Organization	***Deer Valley Unified School District #97***
Phone ***Fax***	***623.376.6840 work, 602.818.8859 cell*** ***None***
Email	***tina.crane@dvusd.org***
Reference #3	
Name ***Title***	***Matt Perfette*** ***Realtor/Soccer Coach***
Organization	***West USA Realty/CCV Stars***
Phone ***Fax***	***623.623.6116 cell*** ***None***
Email	***m.perfette@yahoo.com***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Kari Pikus, BS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analytics Manager II, Data Science and Advanced Analytics***		
# of Years in Classification:	***9.9***	**# of Years with Firm:**	***9.9***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Pikus has more than nine years of industry experience, and presently manages day-to-day analytic and project-related activities for HSAG's external quality review organization (EQRO) contracts, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for several states. In addition, she provides management support and assistance to the California Department of Public Health (CDPH) with the implementation and evaluation of the Skilled Nursing Facility Quality and Accountability Supplemental Program (SNF QASP). Ms. Pikus coordinates and manages several EQRO projects that evaluate aggregated information on timeliness, access, and quality of healthcare services furnished to Medicaid enrollees. She assists with the day-to-day management, reporting, and data validation of various activities. Through this work, Ms. Pikus has gained in-depth understanding of various Medicaid populations.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***May 2008 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Analytics Manager II***

Contract / Project:

State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)

State of Arizona Arizona Health Care Cost Containment System (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Assists states with the administration of consumer satisfaction surveys, such as CAHPS surveys, provider surveys, quality of life surveys, and care management surveys; assists with the development of survey instruments and appropriate sampling methodologies for surveys; assists with oversight on all phases of survey administration and data collection; assists with managing the data analysis and reporting of survey results; conducts presentation of results to stakeholders, when necessary***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Bachelor of Science, Computer Information Systems, 2004

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Suzanne Turla*** ***Nurse Consultant***
Organization	***The State of Hawaii Department of Human Services Med-QUEST Division***
Phone ***Fax***	***808.692.8110*** ***808.692.8087***
Email	***sturla@dhs.hawaii.gov***
Reference #2	
Name ***Title***	***Wendi Medina*** ***Manager, Bureau of Quality Management***
Organization	***Illinois Department of Healthcare and Family Services***
Phone ***Fax***	***217.557.9268*** ***217.557.8800***
Email	***Wendie.Medina@illinois.gov***
Reference #3	
Name ***Title***	***Valerie Collier*** ***Quality Program Manager***
Organization	***Virginia Department of Medical Assistance Services***
Phone ***Fax***	***804.786.2273*** ***804.786.5779***
Email	***Valerie.Collier@dmas.virginia.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Pooja Rangan, MPH, MBBS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Analyst II, Data Science and Advanced Analytics***		
# of Years in Classification:	***1***	**# of Years with Firm:**	***1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Rangan has more than seven years of clinical and research experience in the public health and healthcare industries, with expertise in healthcare analytics, program planning and implementation, policies and procedures, and direct clinical care. In her current role, she provides analytic support for performance measure calculation projects across multiple state evaluations. Ms. Rangan assists performance measure calculation projects for Virginia, Iowa, Colorado, Arizona and Colorado. Additionally, she supports the Quality Rating System (QRS) calculations for Michigan, Ohio, Virginia, and Illinois. The QRS results are provided to consumers within each state to aid them when choosing a health plan. She is also involved in the New Hampshire Premium Evaluation and Iowa Potentially Preventable Events (PPEs) project.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***April 2017 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Informatics Analyst II***

Contract / Project:

State of Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Assists with performance measure calculation activities, data extraction and transformation, data validation, data diagnostics, performance measure calculation; analyzes performance measure results and Consumer Assessment of Healthcare Providers and System (CAHPS®) survey results to assess plan performance and***

	prepare deliverable for the QRS result calculation; validates propensity score matching and statistical testing to evaluate the impact of the NH PAP program on health outcomes; assists with Potentially Preventable Events (PPEs) activities to include assistance with identifying the PPEs, assessing the pattern, stratifying, and analyzing data for disparities
Timeframe:	***November 2014 to March 2017***
Company Name:	***Office of Assessment and Evaluation, Arizona Department of Health Services***
Company Location:	***Phoenix, Arizona***
Position Title:	***Epidemiologist Specialist II***
Contract / Project:	***Maternal Infant Early Childhood Home Visiting Project*** ***Health Start project*** ***High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP)***
Contract / Project Details:	***Assisted the state with program evaluation activities, including review and selection of performance measure, data collection, survey conduction, database management, analysis, annual reports preparation, and presentation to stakeholders; conducted health surveillance activities, including designing, conducting, and analyzing surveys, assessing rates, and creating needs assessments***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Drexel School of Public Health, Philadelphia, Pennsylvania, Master of Public Health, Epidemiology, and Biostatistics, 2014

Kasturba Medical College, Manipal University, Karnataka, India, Bachelor of Medicine and Bachelor of Surgery (MBBS), 2010

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Enid Quintana Torres*** ***Epidemiology Program Manager***
Organization	***Arizona Department of Health Services***
Phone ***Fax***	***800.232.1676*** ***602.542.1843***
Email	***Enid.quintana-torres@azdhs.gov***

Reference #2	
Name ***Title***	***Manjiri Joshi*** ***Program Research Specialist***
Organization	***Health Research Inc/ New York State Department of Health***
Phone ***Fax***	***402.707.0138*** ***None***
Email	***Manjiri.vj@gmail.com***
Reference #3	
Name ***Title***	***Sara Rumann*** ***Health Start Program Manager***
Organization	***Arizona Department of Health Services***
Phone ***Fax***	***602.364.1421*** ***602.364.1494***
Email	***Sara.rumann@azdhs.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Maureen Sharp, MPH, BSBA, AASN, RN, PMP, CPC***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Director, State and Corporate Services***		
# of Years in Classification:	***13***	**# of Years with Firm:**	***1.25***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Sharp has more than 25 years of experience in the healthcare industry, with expertise in multi-state health policy and Medicaid consulting, project management, healthcare claims and reporting, and financial management. As director of State and Corporate Services, she is responsible for providing professional communications with assigned customers and ensuring deliverables are of the highest quality. Ms. Sharp applies state and federal Medicaid managed care regulations to activities, adheres to project communication plans, and complies with all reporting requirements so that projects are on task, on time, and within budget. This includes drafting project budgets, performing financial oversight, management of risk factors, and the escalation of unresolved issues. She analyzes data, makes recommendations, develops strategies and solutions, and measures progress against objectives and success criteria.
Ms. Sharp also leads compliance reviews of Medicaid managed care organizations (MCOs). In this role, she develops and maintains effective working relationships with internal and external stakeholders and facilitates large collaborative stakeholder groups.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***November 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Director, State and Corporate Services***

Contract / Project: ***State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)***

State of Iowa Department of Human Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

Contract / Project Details: ***Provides professional communications with assigned customers and ensuring deliverables are of the highest quality; accountable for oral and written communications as a primary point of contact for the customer; applies state and federal Medicaid managed care***

regulations to activities; adheres to project communication plans; complies with all reporting requirements so that projects are on task, on time, and within budget, including drafting project budgets, performing financial oversight, management of risk factors, and the escalation of unresolved issues; analyzes data, makes recommendations, develops strategies and solutions, and measures progress against objectives and success criteria; leads compliance reviews and readiness reviews of Medicaid managed care organizations (MCOs); and develops and maintains effective working relationships with internal and external stakeholders and facilitates large collaborative stakeholder groups

Timeframe:	***November 2013 to October 2016***
Company Name:	***Burns & Associates***
Company Location:	***Phoenix, AZ***
Position Title:	***Senior Consultant (Project Manager)***
Contract / Project Details:	***Team leader and participant on Medicaid customer engagements focused on managing new initiatives/projects; developed project plans, performed quantitative/qualitative analysis, researched regulatory issues, and collaborated on implementation; facilitated monthly customer steering meetings and team building, and created and managed timeline and final reports, including analysis reports***

Timeframe:	***February 2011 to November 2013***
Company Name:	***Arizona Health Care Cost Containment System (AHCCCS)***
Company Location:	***Phoenix, AZ***
Position Title:	***Administrator, Office of Medical Policy, Analytics and Coding***
Contract / Project Details:	***Led multi-functional operations and skilled staff totaling 11 data analysts, IT developers, RN/CPC and other professionals; planned, implemented, and assessed efforts with a focus on overseeing design/development of custom reports to meet agency needs; teamed with legal staff to comply with privacy regulations; anticipated needs and ensured relevant data and reports to guide strategic decision making on a $9B Medicaid program serving 1.2 million members to improve cost effectiveness, care coordination, and care quality***

Timeframe:	***April 2005 to February 2011***
Company Name:	***Arizona Health Care Cost Containment System (AHCCCS)***
Company Location:	***Phoenix, AZ***
Position Title:	***Medical Policy Manager, Office of Medical Policy, Analytics and Coding***
Contract / Project Details:	***Provided direction and oversight of the AHCCCS Medical Policy Manual, including research and analysis; member of the agency team that developed the AZ Administrative code; chairman of the inter-divisional, executive-level AHCCCS Policy Committee, tasked with medical policy decisions; provided oversight and monitoring for implementation of new or revised CPT/HCPCS and ICD-9 (subsequently transitioned to ICD-10) diagnosis codes utilized in the AHCCCS system; served as subject matter expert on program clinical/medical coding and provided research and analysis on both clinical and new technology issues***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Tucson, Arizona, Master of Public Health, 2002

University of Arizona, Tucson, Arizona, Bachelor of Science in Business Administration-Accounting and Finance, 1988

Scottsdale Community College, Scottsdale, Arizona Associate of Applied Science-Nursing, 1996

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Registered Nurse, State of Arizona, 1996
Gerontology Certification, Arizona State University, Tempe, AZ, 2003
Certified Professional Coder, CPC, 2007
Project Management Professional, PMP, 2015

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Jason Holst*** ***Quality Improvement Analyst***
Organization	***Bureau of Managed Care Services and Supports*** ***Iowa Medicaid Enterprise*** ***Iowa Department of Human Services***
Phone ***Fax***	***515.974.3070*** ***515.725.1360***
Email	***Jholst@dhs.state.ia.us***
Reference #2	
Name ***Title***	***Tom Curtis*** ***Quality Manager***
Organization	***Managed Care Plan Division*** ***Michigan Department of Health and Human Services***
Phone ***Fax***	***517.284.1152*** ***517.241.5713***
Email	***CurtisT2@michigan.gov***
Reference #3	
Name ***Title***	***Kathleen M. Haines*** ***Manager***
Organization	***Performance Measurement Section*** ***Behavioral Health and Development Disabilities Administration*** ***Michigan Department of Health and Human Services***
Phone ***Fax***	***515.335.0179*** ***517.335.5376***
Email	***HainesK@michigan.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Robin Tigert, BS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Informatics Analyst I, Data Science and Advanced Analytics***		
# of Years in Classification:	***3***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Tigert has more than five years of experience in the healthcare industry, with expertise in project management, bioinformatics, and federal regulations and procedures. She presently serves as an analyst for the Healthcare Effectiveness Data and Information Set (HEDIS®) reporting team, which is responsible for producing annual technical and aggregate reports for state Medicaid agencies as part of the external quality review organization (EQRO) contracts for multiple states. Ms. Tigert analyzes HEDIS and non-HEDIS measure data for the states of Arizona, California, Colorado, Florida, Hawaii, Illinois, Iowa, Michigan, Utah, Vermont, and Virginia, respectively. In relation to the state EQRO activities, Ms. Tigert works closely with internal National Committee for Quality Assurance (NCQA) certified HEDIS auditors and is the lead analyst on HEDIS Compliance Audit activities, such as Interactive Data Submission System (IDSS) file rate review and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey sample frame validation. Ms. Tigert also serves as lead analyst on Centers for the Medicare & Medicaid Services' (CMS) Financial Alignment Initiative (FAI) contract in collaboration with the National Opinion Research Center (NORC) at the University of Chicago for capitated model tasks. These tasks include analysis and evaluation of rejected pharmacy claims submitted by health plans participating in the FAI, and the production of plan-specific and comprehensive reports for CMS.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe:	***July 2015 to Present***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Analyst***
Contract / Project:	***State of Arizona Health Care Cost Containment System (EQRO contract)***
	State of California Department of HealthCare Services (EQRO contract)
	State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Florida Agency for Health Care Administration (EQRO contract)

State of Hawaii Department of Human Services (EQRO contract)

Illinois Department of Healthcare and Family Services (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of Michigan Department of Health and Human Services (EQRO contract)

State of Utah Department of Health (EQRO contract)

State of Vermont Agency of Human Services (EQRO contract)

Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details: ***Assists states with performance measure calculation activities; assists with review and selection of performance measures, data validation, performance measure calculation, rate reviews, statistical testing and trending deliverable preparation, and presentation of results to stakeholders***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Stockton University, Galloway Township, New Jersey, Bachelor of Science in Biology, 2008

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Shawni Smith*** ***Regional Director, Quality and Systems Improvement***
Organization	***American Heart Association***
Phone ***Fax***	***213.291.7146*** ***None***
Email	***Shawni.smith@heart.org***
Reference #2	
Name ***Title***	***Lauren Gavin*** ***Health Insurance Specialist, Medicare-Medicaid Coordination Office***
Organization	***CMS***
Phone ***Fax***	***202.205.9270*** ***None***
Email	***Lauren.Gavin@cms.hhs.gov***

Reference #3	
Name ***Title***	***Mary Jane Giesey*** ***Senior Research Analyst, Health Care Research***
Organization	***NORC at the University of Chicago***
Phone ***Fax***	***301.634.9547*** ***None***
Email	***giesey-maryjane@norc.org***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Lauren Young, MPH, BA, CPH***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Healthcare Analyst, Data Science and Advanced Analytics***		
# of Years in Classification:	***2.75***	**# of Years with Firm:**	***2.75***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Young has more than four years of experience in the healthcare industry, with expertise in quantitative and statistical analysis, including the management and transformation of event-based data, as well as the collection and management of study participant data. As a healthcare analyst, she is responsible for conducting research and literature review, performing quantitative and statistical analysis, and drafting reports for assigned projects for state Medicaid customers. She validates results from other analysts and assists in designing methodology and analysis plans. Ms. Young is accountable for reviewing and synthesizing healthcare literature, suggesting recommendations, and drafting reports based on study findings, and uses SAS to evaluate a wide array of data types. She performs analysis, develops study methodology and statistical models, determines sample sizes, manipulates complex databases, as well as tracks and evaluates patterns of care and outcomes. Ms. Young identifies problem areas, develops solutions, and stays abreast of changes in database methods, variable definitions, processes of healthcare delivery, and current analytic methodologies.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***October 2015 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Health Data Analyst II***

Contract / Project: ***State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (EQRO contract)***

State of California Department of Health Care Services (EQRO contract)
State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)
Commonwealth of Virginia Department of Medical Assistance Services (EQRO contract)

Contract / Project Details:	***Assists with the design and execution of encounter data validation (EDV), focused studies, and network adequacy assessments; conducts data analyses, including data review and measure calculation; develops project deliverables such as reports, presentations and workbooks; communicates directly with customers regarding project scope and status updates***

Timeframe:	***August 2013 to May 2015***
Company Name:	***Arizona Department of Health Services***
Company Location:	***Phoenix, Arizona***
Position Title:	***Epidemiologist II***
Contract / Project:	***Sexually Transmitted Disease (STD) Control, Disease Integration and Services, Bureau of Epidemiology & Disease Control***
Contract / Project Details:	***Contributed to design and management of statewide surveillance database; conducted disease specific monitoring activities at the state level; coordinated disease monitoring and investigation with county offices; contributed to annual reporting for federal and state oversight; developed drug-resistance surveillance plans; and participated in original research submitted for publication***

Timeframe:	***August 2012 to August 2013***
Company Name:	***Florida Birth Defects Surveillance Program***
Company Location:	***Tampa, Florida***
Position Title:	***Medical Records Abstractor and Statistical Data Analyst***
Contract / Project:	***Birth Defects Surveillance Projects***
Contract / Project Details:	***Contributed to management of multiple surveillance databases for projects; collected data; participated in research activities, including research submitted for publication***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

College of Public Health at the University of South Florida, Tampa, Florida, Master of Public Health, Epidemiology, 2012

Indiana University Bloomington, Bloomington, Indiana, Bachelor of Arts, Chemistry and Spanish; minors in Portuguese, Latin American, and Caribbean Studies, 2010

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified in Public Health (CPH), National Board of Public Health Examiners, 2012

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Jerry Ware*** ***Quality and Compliance Specialist, Quality Health Improvement Unit***
Organization	***Colorado Department of Health Care Policy and Financing***
Phone ***Fax***	***303.866.2335*** ***None***
Email	***jerry.ware@state.co.us***

Reference #2	
Name ***Title***	***Valerie Collier*** ***Quality Program Manager***
Organization	***Commonwealth of Virginia, Department of Medical Assistance Services***
Phone ***Fax***	***804.786.2273*** ***None***
Email	***Valerie.collier@dmas.virginia.gov***
Reference #3	
Name ***Title***	***Lisa Villarroel, MD, MPH*** ***Medical Director, Bureau of Epidemiology and Disease Control***
Organization	***Arizona Department of Health Services***
Phone ***Fax***	***602.364.3385*** ***None***
Email	***lisa.villarroel@azdhs.gov***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Tanzida Zaman, MPH***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Healthcare Analyst I, Data Science and Advanced Analytics***		
# of Years in Classification:	***1***	**# of Years with Firm:**	***1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

With more than two years of healthcare industry experience in research, surveys, and data analysis, Ms. Zaman works in the state analytics operational area, which focuses on Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, network adequacy studies, and encounter data validation studies. This work requires conducting complex statistical analyses, SAS programming, and concise communication of findings. Ms. Zaman conducts analytic validations and assists in designing statistical analysis plans and defining case selection criteria and variable parameters. She develops, writes, and maintains SAS computer programs, modifies and interprets primary analyses, conducts secondary and exploratory analyses, assists in the development and application of appropriate statistical models, determines sample sizes, manipulates databases and tracks, and evaluates patterns of care and outcomes.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***July 2017 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Healthcare Analyst***

Contract / Project:

State of Nevada Division of Health Care Financing and Policy (EQRO contract)

State of California Department of Health Care Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Bureau of TennCare (EQR services subcontract)

Contract / Project Details: ***Supports EQRO contracts with state Medicaid agencies by successfully collaborating with project lead staff to conduct and validate analyses and deliverables for focused studies, encounter data validation studies, and network adequacy assessments; perform***

	project activities, including drafting project methodologies, data collection, data validation, study indicator calculation, and deliverable preparation
Timeframe:	***January 2017 to June 2017***
Company Name:	***Health Services Advisory Group, Inc.***
Company Location:	***Phoenix, Arizona***
Position Title:	***Healthcare Analyst***
Contract / Project:	***Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)***
Contract / Project Details:	***Assisted in maintaining and creating SAS programs used for creating reports; conducted analyses for research questions used to accurately calculate HCAHPS scores; investigated technical assistance inquiries related to HCAHPS data for hospitals and survey vendors***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Mel and Enid Zuckerman College of Public Health, Tucson, Arizona, Master of Public Health, Epidemiology, 2016
University of Arizona, Tucson, Arizona, Bachelor of Science in Health Science, Physiology, 2014
University of Arizona, Tucson, Bachelor of Arts, Middle Eastern and North African Studies, 2014

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Elizabeth Jacobs*** ***Professor and Program Director, Epidemiology***
Organization	***University of Arizona***
Phone ***Fax***	***520.626.0341*** ***None***
Email	***jacobse@email.arizona.edu***
Reference #2	
Name ***Title***	***Kimberly Fassl*** ***Assistant Director, Student Behavioral Education***
Organization	***University of Arizona***
Phone ***Fax***	***520.626.4868*** ***None***
Email	***kfassl@email.arizona.edu***
Reference #3	
Name ***Title***	***Emily Dykstra*** ***Director, Introductory Biology Labs***
Organization	***University of Arizona***
Phone ***Fax***	***520.621.0626*** ***None***
Email	***edykstra@email.arizona.edu***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Kim (Yuexin) Zhang, MSBA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Healthcare Analyst, Data Science and Advanced Analytics***		
# of Years in Classification:	***1.5***	**# of Years with Firm:**	***1.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Zhang has technical experience working with healthcare data analytics, SAS, and process mapping, with expertise in media analysis, marketing primary research, and digital visualization. As a healthcare analyst, her primary responsibilities include analytic development work on numerous projects for the State Analytics Team. Ms. Zhang uses SAS to evaluate a wide array of data types and performs analyses according to analysis plans. She assists in developing study methodologies, determining sample sizes, manipulating complex databases, as well as tracking and evaluating patterns of care and outcomes.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***September 2016 to Present***
Company Name: ***Health Services Advisory Group, Inc.***
Company Location: ***Phoenix, Arizona***
Position Title: ***Healthcare Analyst, Data Science and Advanced Analytics***

Contract / Project:

State of California Department of Health Care Services (EQRO contract)

State of Colorado Department of Health Care Policy and Financing (EQRO contract)

State of Iowa Department of Human Services (EQRO contract)

State of New Hampshire Department of Health and Human Services (EQRO contract)

State of Ohio Department of Medicaid (EQRO contract)

State of Tennessee Bureau of TennCare (EQR services subcontract)

Contract / Project Details: ***Supports EQRO contracts with state Medicaid agencies by successfully collaborating with project lead staff to conduct and validate analyses and deliverables for focused studies, encounter data validation studies, and network adequacy assessment; specific tasks vary by project and include (but are not limited to) data***

collection, data validation, study indicator calculation, rate review, and deliverable preparation

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Master of Science in Business Analytics, 2016
Guangdong University of Foreign Studies, Guangzhou, China, Bachelor of Science in Marketing, 2015

Professional Training

Johns Hopkins University, Online, The Data Scientist's Toolbox, Certificate Program, January 2017
Duke University, Online, Data Visualization and Communication with Tableau, Certificate Program, December 2016

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

SAS Base 9 Programmer, 2015

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name *Title*	*Yue Yuan* *Analyst*
Organization	*Elegran Real Estate*
Phone *Fax*	*212.729.5712* *None*
Email	*info@elegran.com*
Reference #2	
Name *Title*	*Mary Fachman* *Assistant Director*
Organization	*Arizona State University, W.P. Carey School of Business, Career Services Department*
Phone *Fax*	*480.727.3430* *None*
Email	*Mary.m.fachman@asu.edu*
Reference #3	
Name *Title*	*Ben Conner* *SAS Developer, Data Science and Advanced Analytics*
Organization	*Health Services Advisory Group, Inc.*
Phone *Fax*	*602.801.6526* *None*
Email	*BConner@hsag.com*

Subcontractor: DataStat, Inc. Key Staff Resume

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Health Services Advisory Group, Inc.***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	***X***

The following information requested pertains to the individual being proposed for this project.			
Name:	***Marielle S. Weindorf***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Health Care Research Director***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***23***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Weindorf joined DataStat in 1995 where she presently manages contractual and budgetary issues with DataStat customers. At the outset of projects, she is typically the primary customer contact, consulting on the design and implementation of the project, and remains a participant in ongoing project management of projects throughout the project life cycle. Ms. Weindorf is very familiar with all the methodological and protocol issues surrounding the organization and execution of statewide health plan, medical group, physician-level, and hospital projects, and has provided project control and customer liaison support for many of DataStat's large-scale projects. In addition, Ms. Weindorf serves as DataStat's chief liaison with the NCQA on all issues related to CAHPS® HEDIS® administration.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe: ***September 1995 to Present***
Company Name: ***DataStat, Inc.***
Company Location: ***Ann Arbor, Michigan***
Position Title: ***Healthcare Research Director***

Contract / Project: ***Subcontractor to Health Services Advisory Group EQRO contracts, including:***

State of Nevada (CAHPS surveys)

State of Arizona Health Care Cost Containment System (CAHPS surveys, Home- and Community-Based Services [HCBS] CAHPS survey)

State of California (CAHPS surveys)

State of Colorado (CAHPS Surveys, Patient-Centered Medical Home [PCMH] CAHPS surveys, ECHO survey)

State of Hawaii (CAHPS surveys)

State of Illinois (CAHPS surveys)

State of Ohio (CAHPS surveys, Provider survey, Care Management survey, Quality of Life survey)

Commonwealth of Virginia (CAHPS surveys)

Contract / Project Details: ***Conducts a variety of consumer satisfaction surveys, such as CAHPS surveys, provider surveys, quality of life surveys, and care management surveys, for state EQRO customers; manages contractual and budgetary issues; serves as primary customer contact and remains as consultant in ongoing management over project life cycle, through attendance at status meetings and as consultant for report design; has expertise covering the methodological and protocol issues involved in the organization and execution of statewide health plan, medical group, physician level and hospital projects; provides executive oversight, project control and customer liaison support for these projects, with an emphasis on projects in academic settings, as well as complex survey projects requiring specialized sample and protocol design***

Timeframe: ***1995 to Present***
Company Name: ***DataStat, Inc.***
Company Location: ***Ann Arbor, Michigan***
Position Title: ***Healthcare Research Director***
Contract / Project: ***State of Minnesota Department of Human Services: Adult Medicaid CAHPS Survey Project***

Contract / Project Details: ***Conducts CAHPS survey project for Minnesota DHS; goal of this project is to assess consumer satisfaction with access and quality of care provided by managed care organizations (MCOs) to approximately 24,000 enrollees in nine different health plans across six different programs***

Timeframe: ***1995 to Present***
Company Name: ***DataStat, Inc.***
Company Location: ***Ann Arbor, Michigan***
Position Title: ***Healthcare Research Director***
Contract / Project: ***New York State Department of Health (NYSDOH): CAHPS Adult Medicaid Survey Project***

Contract / Project Details: ***Statewide CAHPS Adult or Child Medicaid survey project which entails surveying the adult population enrolled in the NYSDOH Medicaid program. A total of approximately 35,000 enrollees are sampled across 20 to 25 managed care organizations serving the community, some of which are exclusively Medicaid providers, while others provide healthcare services to both Medicaid and Commercial populations. The project uses the current CAHPS Adult survey instrument, released by the National Committee for Quality Assurance (NCQA), with the addition of NYSDOH specific questions. DataStat employs a mixed mode survey protocol consisting of four mailing waves accompanied by Computer Assisted Telephone Interviewing (CATI) follow-up. Project data are reported to the National CAHPS Benchmarking Database. We produce individual plan and aggregate reports, with extensive customized analysis and graphical presentations.***

Timeframe: ***1995 to Present***
Company Name: ***DataStat, Inc.***
Company Location: ***Ann Arbor, Michigan***
Position Title: ***Healthcare Research Director***

Contract / Project:	***CMS Health Outcomes Survey: Modified***
Contract / Project Details:	***Directs and manages all aspects of this project, performed for NCQA under contract to the Centers for Medicare & Medicaid Services (CMS), with the goal of assessing the health and function of the most frail and elderly Medicare population; project requires coordination with RTI to generate and validate sampling processes; coordinating 50+ health plans in contracting and generating appropriate member lists and required survey materials; works with the project team to develop sampling and field strategies; prepares field and methodology documentation; manages NCQA data submission processes; and coordinates task leaders for mail, CATI, and data management processes.***

Timeframe:	***1995 to Present***
Company Name:	***DataStat, Inc.***
Company Location:	***Ann Arbor, Michigan***
Position Title:	***Healthcare Research Director***
Contract / Project:	***CMS Health Outcomes Survey***
Contract / Project Details:	***Directs and manages all aspects of projects performed for individual health plans as a component of NCQA accreditation; HOS project assesses the health of select Medicare populations and monitors changes in functional status, using an outcomes measurement basis; works with project team to develop sampling and field strategies; prepares field and methodology documentation; manages NCQA data submission processes; coordinates task leaders for mail, CATI, and data management processes***

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Michigan, Ann Arbor, MI, Bachelor of Arts, Political Science, 1987

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference #1	
Name ***Title***	***Anne Schettine*** ***Director, Quality Measurement***
Organization	***NY State Department of Health, Office of Health Insurance Programs***
Phone ***Fax***	***518.486.9012*** ***None***
Email	***ams13@health.state.ny.us***

Reference #2	
Name Title	Beverly Weidmer Survey Director
Organization	RAND Corporation
Phone Fax	310.393.0411 x6788 None
Email	Beverly_Weidmer@rand.org
Reference #3	
Name Title	Norman Thurston, Ph.D. Director Office of Health Care Statistics
Organization	Utah Department of Health
Phone Fax	801.538.7052 None
Email	nthurston@utah.gov

Section VIII – Other Informational Material

Vendors shall include any other applicable reference material in this section clearly cross referenced with the proposal.

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Attachment B – QAPI Goals and Objectives Tracking Table	*VIII.37*
Attachment C – External Quality Review Technical Report	*VIII.48*
Attachment D – Internal Quality Assurance Program (IQAP) On-site Review of Compliance Report	*VIII.189*
Attachment E – Compliance Review Report of CMO	*VIII.205*
Attachment F – HSAG's NCQA HEDIS (CAHPS) Survey Vendor Certificate	*VIII.228*
Attachment G – DataStat's NCQA HEDIS (CAHPS) Survey Vendor Certificate	*VIII.230*
Attachment H – Licensed Organization Certificate	*VIII.232*
Attachment I – Project Team Organizational Chart	*VIII.234*
Attachment J – Current Year Interim	*VIII.236*
Attachment K – HSAG – 2017 Fiscal Year Financial Statements	*VIII.239*
Attachment L – HSAG – 2016 Fiscal Year Financial Statements	*VIII.259*

Attachment A

EXTERNAL QUALITY REVIEW SUMMARY RESULTS

As referenced in Section V, 2.1.3.5.

Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2016–2017
External Quality Review Summary

October 2017

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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2. Introduction

In accordance with 42 CFR 438.350 and 438.356, each State that contracts with managed care organizations (MCOs) must ensure that a qualified external quality review organization (EQRO) performs an annual external quality review (EQR) for each contracting MCO. In accordance with these rules, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR 438.358. The mandatory EQR activities were internal quality assurance program (IQAP) compliance monitoring, validation of performance measures, and validation of performance improvement projects (PIPs). The purpose of external quality review is to assess each MCO's strengths and weaknesses and provide an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each MCO provides.

IQAP Compliance Monitoring

SFY 2014–2015 was the first year of a three-year cycle of reviews. The purpose of the internal quality assurance program (IQAP) compliance monitoring review was to determine each MCO's compliance with federal and the State's managed care standards in the areas of access, structure and operations, and measurement and improvement. For any areas that did not achieve full compliance, MCOs were required to submit a corrective action plan to DHCFP. The corrective action plans were reviewed and approved in the second year of the three-year cycle, SFY 2015–2016. SFY 2016–2017 was the last year of the three-year cycle of IQAP compliance monitoring. There were no outstanding areas to review in the third year. SFY 2017–2018 will initiate a new three-year cycle of IQAP compliance reviews.

Validation of HEDIS Performance Measures

HSAG conducted Healthcare Effectiveness Data and Information Set (HEDIS®[1]) compliance audits to validate the performance measures required by the State. Each MCO calculated and reported its performance measure rate using HEDIS methodology for each contractually required performance measure. HSAG validated the performance measure results and found that all measures were produced according to HEDIS specifications. This Summary Report displays the performance measure results for the MCOs as well as the Statewide results (**Amerigroup** and **HPN** combined). This report also displays the results of the FY 2015–2016 Annual Quality Strategy Evaluation, which includes the HEDIS 2015 rate, QISMC goal, HEDIS 2016 rate and an indication if the QISMC goal was attained.

Validation of PIPs

Nevada MCOs are contractually required to conduct and submit to HSAG for validation, PIPs. In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents,*** and ***Behavioral Health Hospital***

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

Readmissions. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services. HSAG validated the PIP Modules submitted by the MCOs. Both MCOs completed all five PIP Modules and the SFY 2016-2017 PIPs are closed.

Additional detail about the information contained in this summary report may be found in the SFY 2016-2017 External Quality Review Technical Report, which will be posted to the DHCFP website in November 2017. Additional details about the quality activities implemented by MCOs, including MCO-administered Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, and a follow-up on prior year's recommendations are also contained in the SFY 2016-2017 External Quality Review Technical Report.

3. Growth of the Nevada Managed Care Program

In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment compared to prior years.

Table 3-1 below presents the managed care enrollment numbers as of June each year from 2013 through 2017.

Table 3-1—Nevada Medicaid and Check Up Managed Care Demographics

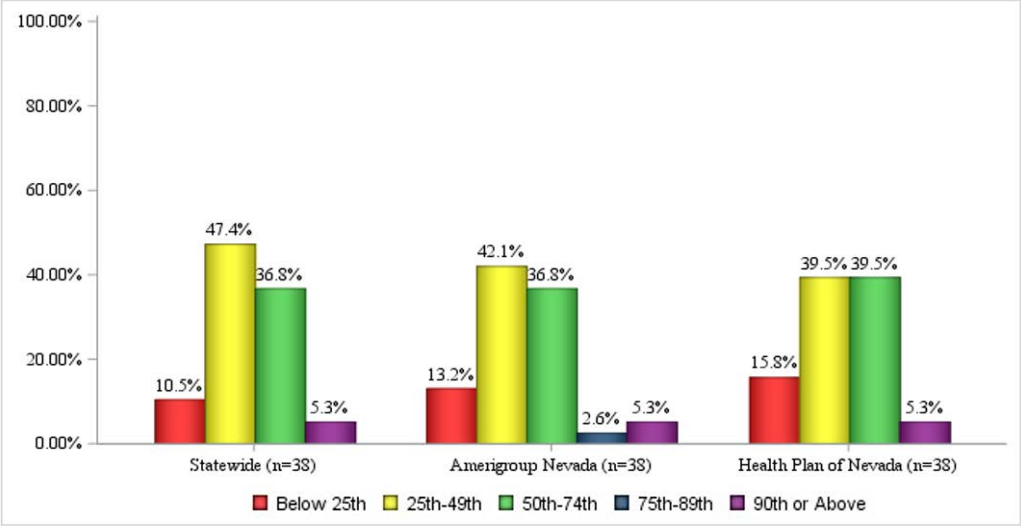
Gender/Age Band	June 2013 Members	June 2014 Members	June 2015 Members	June 2016 Members	June 2017 Members
Total Medicaid	174,932	321,001	384,983	429,132	455,080
Total CHIP	18,523	20,774	18,073	21,252	22,960
Total Medicaid and CHIP	**193,455**	**341,775**	**403,056**	**450,384**	**478,040**

As the table shows, the number of persons enrolled in managed care more than doubled from 2013 to 2015. From 2013 to 2017, the population served in managed care grew by more than 147 percent.

4. HEDIS 2017 Summary of Performance

Figure 4-1 below shows the percentage of Medicaid population rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to HEDIS National Medicaid Percentiles.

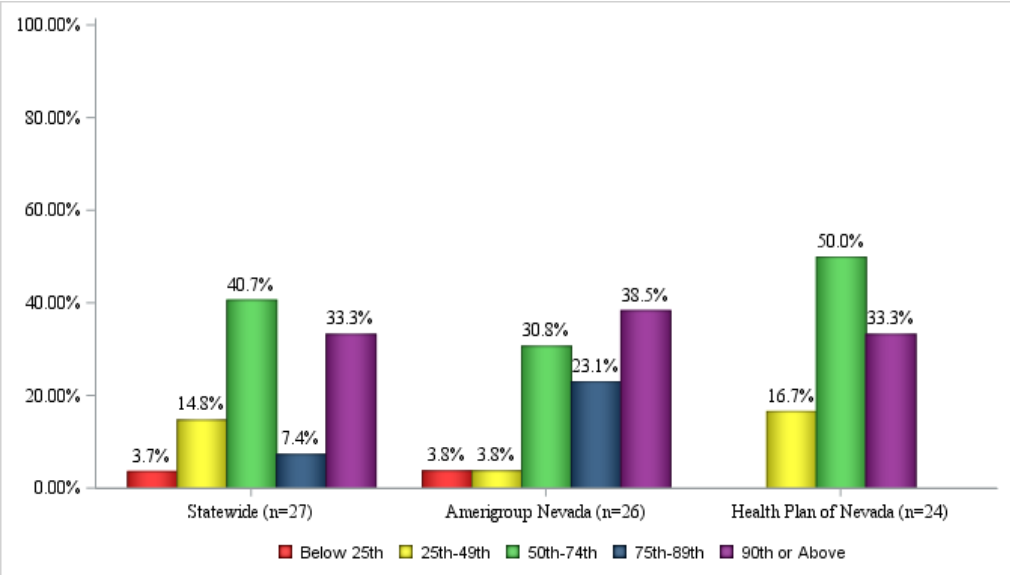
Figure 4-1: Comparison of Nevada MCO 2017 Medicaid Performance Measures to HEDIS Medicaid National Percentiles



Note: Percentages may not total 100 percent due to rounding.

Figure 4-2 below shows the percentage of Nevada Check Up rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to HEDIS National Medicaid Percentiles.

Figure 4-2: Comparison of Nevada MCO 2016 Check Up Performance Measures to HEDIS Medicaid National Percentiles



Nevada Medicaid HEDIS Rates and Percentile Ranking

Table 4-2 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on rate comparisons to the national Medicaid percentiles for HEDIS 2016. Measure results were compared to benchmarks and rated using the following star ratings:

Table 4-1—HEDIS Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

Table 4-2—HEDIS 2017 Results for Medicaid

HEDIS Measure	AGP	HPN	Medicaid
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	93.83% ★★	95.17% ★★	94.55% ★★
Ages 25 Months–6 Years	82.25% ★	83.81% ★	83.08% ★
Ages 7–11 Years	86.59% ★	87.57% ★	87.16% ★
Ages 12–19 Years	82.95% ★	85.51% ★	84.54% ★
Annual Dental Visit (ADV)			
Total	51.63% ★★	53.85% ★★★	52.91% ★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	47.69% ★★	44.77% ★★	45.88% ★★
Childhood Immunization Status (CIS)			
Combination 2	72.92% ★★	73.72% ★★	73.33% ★★
Combination 3	67.13% ★★	71.05% ★★	69.12% ★★
Combination 4	66.67% ★★	71.05% ★★★	68.90% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Combination 5	56.71% ★★	61.07% ★★★	58.93% ★★
Combination 6	36.11% ★★	34.79% ★★	35.44% ★★
Combination 7	56.25% ★★	61.07% ★★★	58.71% ★★★
Combination 8	36.11% ★★	34.79% ★★	35.44% ★★
Combination 9	32.18% ★★	30.41% ★★	31.28% ★★
Combination 10	32.18% ★★	30.41% ★★	31.28% ★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	79.40% ★★★	80.78% ★★★	80.25% ★★★
Combination 2 (Meningococcal, Tdap, HPV)	26.85% NC	27.49% NC	27.25% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	62.50% ★★★	62.77% ★★★	62.64% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.72% ★★	65.21% ★★	66.85% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	70.14% ★★★	71.78% ★★★	71.10% ★★★
Counseling for Nutrition—Total	62.73% ★★★	62.29% ★★	62.47% ★★
Counseling for Physical Activity—Total	56.48% ★★★	59.61% ★★★	58.31% ★★★
Maternity Care			
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	83.33% ★★★	72.75% ★	77.85% ★★
Postpartum Care	62.50% ★★★	59.12% ★★	60.75% ★★
Frequency of Ongoing Prenatal Care (FPC)			
*<21 Percent of Expected Visits**	5.56% ★★★	11.19% ★★	8.47% ★★
≥81 Percent of Expected Visits	62.50% ★★★	60.83% ★★★	61.63% ★★★
Care for Chronic Conditions			

HEDIS Measure	AGP	HPN	Medicaid
Comprehensive Diabetes Care (CDC)			
Hemoglobin A1c (HbA1c) Testing	81.02% ★	82.73% ★	82.10% ★
*HbA1c Poor Control (>9.0%)**	46.30% ★★	42.82% ★★★	44.10% ★★
HbA1c Control (<8.0%)	45.60% ★★	48.42% ★★★	47.38% ★★★
Eye Exam (Retinal) Performed	59.49% ★★★	61.31% ★★★	60.64% ★★★
Medical Attention for Nephropathy	90.28% ★★	90.75% ★★★	90.58% ★★★
Blood Pressure Control (<140/90 mm Hg)	61.11% ★★★	50.36% ★	54.33% ★★
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	56.19% ★★★	53.37% ★★	54.52% ★★
Medication Compliance 75%—Total	32.16% ★★★	32.81% ★★★	32.54% ★★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	79.81% ★★★★★	79.16% ★★★★★	79.52% ★★★★★
30-Day Follow-Up	84.98% ★★★★★	84.20% ★★★★★	84.63% ★★★★★
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD)			
Initiation Phase	43.51% ★★★	43.68% ★★★	43.60% ★★★
Continuation and Maintenance Phase	64.91% ★★★★	49.28% ★★	56.35% ★★★
***Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[2,*]**			
Total	3.74% ★	2.26% ★★	2.92% ★★

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

Nevada Check Up HEDIS Rates and Percentile Ranking

Table 4-3 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the national Medicaid percentiles for HEDIS 2016.

Table 4-3—HEDIS 2017 Results for Nevada Check Up

HEDIS Measure	AGP	HPN	NV Check Up
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	98.18% ★★★★★	98.50% ★★★★★	98.36% ★★★★★
Ages 25 Months–6 Years	89.45% ★★★	89.61% ★★★	89.54% ★★★
Ages 7–11 Years	91.83% ★★★	92.98% ★★★	92.55% ★★★
Ages 12–19 Years	91.08% ★★★	91.29% ★★★	91.22% ★★★
Annual Dental Visit (ADV)			
Total	67.81% ★★★★★	68.88% ★★★★★	68.48% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	60.88% ★★★★	54.74% ★★★	56.79% ★★★
Childhood Immunization Status (CIS)			
Combination 2	91.16% ★★★★★	84.38% ★★★★★	87.39% ★★★★★
Combination 3	82.87% ★★★★★	82.14% ★★★★★	82.47% ★★★★★
Combination 4	81.22% ★★★★★	82.14% ★★★★★	81.73% ★★★★★
Combination 5	72.93% ★★★★★	71.88% ★★★★★	72.34% ★★★★★
Combination 6	47.51% ★★★★	41.52% ★★★	44.18% ★★★
Combination 7	72.38% ★★★★★	71.88% ★★★★★	72.10% ★★★★★
Combination 8	47.51% ★★★★	41.52% ★★★	44.18% ★★★
Combination 9	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Combination 10	44.75% ★★★★	37.50% ★★★	40.72% ★★★

HEDIS Measure	AGP	HPN	NV Check Up
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	83.61% ★★★★	87.59% ★★★★★	86.28% ★★★★
Combination 2 (Meningococcal, Tdap, HPV)	38.46% NC	38.69% NC	38.61% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	78.92% ★★★★★	63.49% ★★★	70.70% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16% ★★★	67.64% ★★	71.34% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	71.30% ★★★	73.24% ★★★	72.52% ★★★
Counseling for Nutrition—Total	65.28% ★★★	61.07% ★★	62.61% ★★
Counseling for Physical Activity—Total	59.72% ★★★	58.39% ★★★	58.88% ★★★
Care for Chronic Conditions			
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	58.43% ★★★	51.02% ★★	53.81% ★★
Medication Compliance 75%—Total	24.72% ★	27.89% ★★	26.69% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	82.50% ★★★★★	NA	80.00% ★★★★★
30-Day Follow-Up	97.50% ★★★★★	NA	92.31% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	41.67% ★★	48.89% ★★★	45.68% ★★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[2,]			
Total	NA	NA	5.71% ★

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

NA (i.e., Small Denominator) indicates the health plan(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.

Plan-Specific Medicaid Results Trended from 2015 to 2017

Table 4-4 and Table 4-5 present MCO-specific Medicaid results from 2015 to 2017. For measures for which lower rates suggest better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline.

Amerigroup Results

Table 4-4—Medicaid HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	91.14%	94.15%	93.83%	2.69
Ages 25 Months–6 Years	81.30%	83.55%	82.25%	0.95
Ages 7–11 Years	85.60%	87.12%	86.59%	0.99
Ages 12–19 Years	81.53%	83.76%	82.95%	1.42
Annual Dental Visit (ADV)				
Total	45.62%	53.21%	51.63%	6.01
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	42.13%	38.43%	47.69%	5.56
Childhood Immunization Status (CIS)				
Combination 2	66.20%	73.15%	72.92%	6.72
Combination 3	60.88%	66.67%	67.13%	6.25
Combination 4	58.80%	65.28%	66.67%	7.87
Combination 5	50.23%	57.18%	56.71%	6.48
Combination 6	33.33%	32.41%	36.11%	2.78
Combination 7	48.38%	56.48%	56.25%	7.87
Combination 8	33.10%	32.41%	36.11%	3.01
Combination 9	28.24%	29.63%	32.18%	3.94
Combination 10	28.01%	29.63%	32.18%	4.17

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	71.93%	79.40%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	26.85%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	50.58%	52.78%	62.50%	11.92
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.66%	66.33%	68.72%	3.06
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	64.12%	70.14%	NC
Counseling for Nutrition—Total	—	54.40%	62.73%	NC
Counseling for Physical Activity—Total[1]	—	43.75%	56.48%	NC
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	69.77%	75.41%	83.33%	13.56
Postpartum Care	46.74%	53.16%	62.50%	15.76
Frequency of Ongoing Prenatal Care (FPC)				
*<21 Percent of Expected Visits**	15.81%	17.80%	5.56%	-10.25
≥81 Percent of Expected Visits	52.33%	56.44%	62.50%	10.17
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)[1]				
Hemoglobin A1c (HbA1c) Testing	81.90%	79.63%	81.02%	-0.88
*HbA1c Poor Control (>9.0%)**	46.40%	46.76%	46.30%	-0.10
HbA1c Control (<8.0%)	43.16%	46.30%	45.60%	2.44
Eye Exam (Retinal) Performed	55.45%	55.09%	59.49%	4.04
Medical Attention for Nephropathy	75.17%	89.58%	90.28%	15.11
Blood Pressure Control (<140/90 mm Hg)	62.18%	55.32%	61.11%	-1.07
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	50.22%	56.19%	NC
Medication Compliance 75%—Total	—	26.84%	32.16%	NC

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	53.02%	52.99%	79.81%	26.79
30-Day Follow-Up	63.14%	64.55%	84.98%	21.84
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	36.68%	43.51%	NC
Continuation and Maintenance Phase	—	40.91%	64.91%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]				
Total	—	0.00%	3.74%	NC

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

HPN Results

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	91.42%	94.80%	95.17%	3.75
Ages 25 Months–6 Years	79.24%	84.29%	83.81%	4.57
Ages 7–11 Years	83.93%	87.36%	87.57%	3.64
Ages 12–19 Years	80.80%	85.21%	85.51%	4.71
Annual Dental Visit (ADV)				
Total	51.12%	55.03%	53.85%	2.73
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	37.47%	44.04%	44.77%	7.30
Childhood Immunization Status (CIS)				
Combination 2	70.80%	74.94%	73.72%	2.92
Combination 3	66.18%	70.32%	71.05%	4.87
Combination 4	66.18%	70.07%	71.05%	4.87
Combination 5	53.04%	55.72%	61.07%	8.03
Combination 6	39.42%	38.44%	34.79%	-4.63
Combination 7	53.04%	55.72%	61.07%	8.03
Combination 8	39.42%	38.44%	34.79%	-4.63
Combination 9	32.36%	31.14%	30.41%	-1.95
Combination 10	32.36%	31.14%	30.41%	-1.95
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	79.81%	80.78%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	27.49%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	51.58%	53.77%	62.77%	11.19

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.83%	64.48%	65.21%	4.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	70.32%	71.78%	NC
Counseling for Nutrition—Total	—	57.91%	62.29%	NC
Counseling for Physical Activity—Total[1]	—	52.07%	59.61%	NC
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	77.62%	73.97%	72.75%	-4.87
Postpartum Care	58.88%	57.18%	59.12%	0.24
Frequency of Ongoing Prenatal Care (FPC)				
*<21 Percent of Expected Visits**	17.03%	14.60%	11.19%	-5.84
≥81 Percent of Expected Visits	51.34%	52.07%	60.83%	9.49
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)[1]				
Hemoglobin A1c (HbA1c) Testing	84.18%	85.64%	82.73%	-1.45
*HbA1c Poor Control (>9.0%)**	44.53%	45.74%	42.82%	-1.71
HbA1c Control (<8.0%)	43.80%	46.47%	48.42%	4.62
Eye Exam (Retinal) Performed	55.96%	56.93%	61.31%	5.35
Medical Attention for Nephropathy	82.73%	92.21%	90.75%	8.02
Blood Pressure Control (<140/90 mm Hg)	70.32%	60.83%	50.36%	-19.96
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	46.96%	53.37%	NC
Medication Compliance 75%—Total	—	24.14%	32.81%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	48.49%	56.51%	79.16%	30.67
30-Day Follow-Up	66.89%	69.41%	84.20%	17.31

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	46.65%	43.68%	NC
Continuation and Maintenance Phase	—	58.02%	49.28%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,]*				
Total	—	1.80%	2.26%	NC

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

Plan-Specific Nevada Check Up Results Trended from 2015 to 2017

Table 4-6 and Table 4-7 present MCO-specific Nevada Check Up results from 2015 to 2017. For measures for which lower rates suggest better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline.

Amerigroup Results

Table 4-6—Nevada Check Up HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	95.83%	98.73%	98.18%	2.35
Ages 25 Months–6 Years	90.48%	89.53%	89.45%	-1.03
Ages 7–11 Years	92.62%	92.91%	91.83%	-0.79
Ages 12–19 Years	92.18%	88.95%	91.08%	-1.10
Annual Dental Visit (ADV)				
Total	64.48%	67.05%	67.81%	3.33
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	56.48%	56.34%	60.88%	4.40
Childhood Immunization Status (CIS)				
Combination 2	74.55%	85.90%	91.16%	16.61
Combination 3	73.64%	78.21%	82.87%	9.23
Combination 4	73.64%	77.56%	81.22%	7.58
Combination 5	54.55%	68.59%	72.93%	18.38
Combination 6	45.45%	46.79%	47.51%	2.06
Combination 7	54.55%	67.95%	72.38%	17.83
Combination 8	45.45%	46.79%	47.51%	2.06
Combination 9	32.73%	42.95%	44.75%	12.02
Combination 10	32.73%	42.95%	44.75%	12.02
Immunizations for Adolescents (IMA)				

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Combination 1 (Meningococcal, Tdap)	—	81.61%	83.61%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	38.46%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	70.37%	78.05%	78.92%	8.55
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.30%	70.28%	76.16%	4.86
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	62.04%	71.30%	NC
Counseling for Nutrition—Total	—	55.56%	65.28%	NC
Counseling for Physical Activity—Total[1]	—	47.69%	59.72%	NC
Care for Chronic Conditions				
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	47.76%	58.43%	NC
Medication Compliance 75%—Total	—	26.87%	24.72%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	NA	84.85%	82.50%	NC
30-Day Follow-Up	NA	93.94%	97.50%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	41.67%	NC
Continuation and Maintenance Phase	—	NA	NA	NC
***Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[2,*]**				
Total	—	NA	NA	NC

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Not Applicable due to a small denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

HPN Results

Table 4-7—Nevada Check Up HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	94.70%	99.48%	98.50%	3.80
Ages 25 Months–6 Years	87.20%	89.55%	89.61%	2.41
Ages 7–11 Years	93.83%	93.54%	92.98%	-0.85
Ages 12–19 Years	90.79%	90.78%	91.29%	0.50
Annual Dental Visit (ADV)				
Total	69.50%	70.11%	68.88%	-0.62
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	55.47%	52.83%	54.74%	-0.73
Childhood Immunization Status (CIS)				
Combination 2	83.46%	87.93%	84.38%	0.92
Combination 3	77.17%	84.48%	82.14%	4.97
Combination 4	76.38%	83.91%	82.14%	5.76
Combination 5	66.14%	79.89%	71.88%	5.74
Combination 6	48.03%	52.30%	41.52%	-6.51
Combination 7	65.35%	79.31%	71.88%	6.53
Combination 8	47.24%	51.72%	41.52%	-5.72
Combination 9	42.52%	50.00%	37.50%	-5.02
Combination 10	41.73%	49.43%	37.50%	-4.23
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	87.35%	87.59%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	38.69%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	60.00%	68.00%	63.49%	3.49
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95%	70.13%	67.64%	-4.31

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	72.02%	73.24%	NC
Counseling for Nutrition—Total	—	60.34%	61.07%	NC
Counseling for Physical Activity—Total[1]	—	57.18%	58.39%	NC
Care for Chronic Conditions				
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	47.62%	51.02%	NC
Medication Compliance 75%—Total	—	26.98%	27.89%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	NA	NA	NA	NC
30-Day Follow-Up	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	39.53%	48.89%	NC
Continuation and Maintenance Phase	—	NA	NA	NC
***Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[2,*]**				
Total	—	NA	NA	NC

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Small Denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

5. Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, HSAG developed the Quality Strategy Tracking Table. The Quality Strategy Tracking Table lists each of the six goals and the objectives used to measure achievement of the goals. SFY 2014–2015 marked the baseline year of measurement for the Quality Strategy goals and objectives and also establishes the QISMC goal for each of the objectives, except where indicated. Table 5-1 below shows the MCOs' achievement of goals and objectives in SFY 2016–2017.

Table 5-1: Summary of Achievement of SFY 2016–2017 Quality Strategy Goals and Objectives

Metric	Amerigroup Medicaid	Amerigroup Check Up	HPN Medicaid	HPN Check Up
Number of Comparable Rates (Baseline to Current Year)	41	28	41	27
Number of Rates That Improved	28/41 (68%)	20/28 (71%)	24/41 (59%)	10/27 (37%)
Number of Rates That Stayed the Same	3/41 (7%)	3/28 (11%)	3/41 (7%)	3/27 (11%)
Number of Rates That Achieved QISMC Goal	25/41 (61%)	20/28 (71%)	25/41 (61%)	10/27 (37%)
Number of Rates That Declined	10/41 (24%)	5/28 (18%)	14/41 (34%)	14/27 (52%)

Attachment A details the 2015 baseline measurement for each objective, the QISMC goal, and the HEDIS 2017 rate for each MCO.

6. Overall Conclusions and Summary of Next Steps

Of the three areas most critical to external quality review as stated in the federal regulations—access to and timeliness and quality of care furnished by the MCOs—the MCOs demonstrated mixed results with performance measures that fell within all three domains.

Quality of Care

The MCOs demonstrated above average performance for many quality-related performance measures. The most notable performance, however, was with *Follow-Up After Hospitalization for Mental Illness*, where both Amerigroup and HPN achieved rates above the national Medicaid 90th percentile for both the 7-day and 30-day indicators.

Both MCOs demonstrated opportunities for improvement with several quality-related measures. The measures listed below fell below the national Medicaid 25th percentile.

Amerigroup

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*

HPN

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Blood Pressure Control (140/90 mmHg)*

Next Steps

During the **January 2018** meeting, Amerigroup and HPN should each present the respective MCO's evaluation of performance that led to the improvement with the measure, *Follow-Up After Hospitalization for Mental Illness*. The MCOs should describe:

- The previous analyses that were performed to identify appropriate interventions to be applied.
- The interventions that were applied and those that had the greatest effect.
- The MCO's strategy, including any planned interventions that haven't yet been applied, to ensure the improvement is sustained long-term.

For measures that fell below the national Medicaid 25th percentile, MCOs should present:

- Analyses of numerator noncompliance and notation of any disparities in geographic location, race, ethnicity, age-band, or gender.
- If possible, provide a comparison of the accuracy of contact information between numerator compliant members and those members that were not numerator compliant for the measure.
- The potential causes that can be addressed by the MCO to improve rates for these measures.

- The planned interventions to improve rates.
- The MCO's evaluation plan to evaluate the effectiveness of interventions early so the MCO doesn't waste time and resources on ineffective interventions.

Access to and Timeliness of Care

The quality evaluations performed by Amerigroup and HPN indicated that the supply of available providers may have been strained by the increase in Medicaid managed care membership from 2013 to 2017. An increase in the membership without a concomitant increase in available provider appointments has the potential to negatively impact access-related performance measures, like *Children's and Adolescents' Access to Primary Care Practitioners*, which demonstrated an opportunity for improvement for both MCOs and *Timeliness of Prenatal Care*, which was an opportunity for improvement for HPN. A perceived lack of available appointments for members also has the potential to affect access-related measures collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Next Steps

During SFY 2016-2017, Amerigroup and HPN presented strategies each MCO implemented to increase availability of providers. Those strategies included using mobile health clinics, expanding office hours in primary care provider locations, and increasing the number of provider relations consultants to initiate the contracting process with new providers. The new MCO contract, which began on July 1, 2017, requires all MCOs to individually complete secret shopper surveys to assess the availability of appointments. For the **April 2018** meeting, all MCOs shall present:

- The MCO's methodology and timeline for completing the secret shopper survey, including but not limited to:
  - The sampling approach to generate the list of provider locations that will be surveyed (include number of oversampling).
  - The provider types to be surveyed and total number of surveys to be completed by type.
  - An example survey script that will be used.
  - An example of the type of clinical scenarios used by provider specialty.
  - The analysis plan the MCO will use to determine if appointment availability standards were met or within acceptable ranges where appointment availability standards were not defined by the MCO contract.

The SFY 2014-2015 Provider Network Access Analyses report contains the most recent managed care secret shopper survey performed by HSAG. MCO staff members may access the report at the following link to learn more about the methodology used for the study, although MCOs may use a different survey methodology: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2014-2015_NetAdeqReport_F1.pdf.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	94.15%	92.03%	93.83%	94.80%	92.28%	95.17%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	83.55%	83.17%	82.25%	84.29%	81.32%	83.81%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	87.12%	87.04%	86.59%	87.36%	85.54%	87.57%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	83.76%	83.38%	82.95%	85.21%	82.72%	85.51%
Objective 1.2:	Increase well-child visits (0–15 months).	52.78%	55.52%	62.50%	53.77%	56.42%	62.77%
Objective 1.3:	Increase well-child visits (3–6 years).	66.33%	69.09%	68.72%	64.48%	64.75%	65.21%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	64.12%	67.71%†	70.14%	70.32%	73.29%†	71.78%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	54.40%	58.96%†	62.73%	57.91%	62.12%†	62.29%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	43.75%	49.38%†	56.48%	52.07%	56.86%†	59.61%
Objective 1.5:	Increase immunizations for adolescents.	71.93%	74.74%†	79.40%	79.81%	81.83%†	80.78%
Objective 1.6:	Increase annual dental visits for children.	53.21%	51.06%	51.63%	55.03%	56.01%	53.85%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	24.59%	32.13%†	R*	29.68%	36.71%†	R*
Objective 1.8:	Increase adolescent well-care visits.	38.43%	47.92%	47.69%	44.04%	43.72%	44.77%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.9a:	Increase childhood immunization status (Combination 2).	73.15%	69.58%	72.92%	74.94%	73.72%	73.72%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	66.67%	64.79%	67.13%	70.32%	69.56%	71.05%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	65.28%	62.92%	66.67%	70.07%	69.56%	71.05%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	57.18%	55.21%	56.71%	55.72%	57.74%	61.07%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	32.41%	40.00%	36.11%	38.44%	45.48%	34.79%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	56.48%	53.54%	56.25%	55.72%	57.74%	61.07%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	32.41%	39.79%	36.11%	38.44%	45.48%	34.79%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	29.63%	35.42%	32.18%	31.14%	39.12%	30.41%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	29.63%	35.21%	32.18%	31.14%	39.12%	30.41%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	79.63%	83.71%	81.02%	85.64%	85.76%	82.73%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.76%	41.76%	46.30%	45.74%	40.08%	42.82%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	46.30%	48.84%	45.60%	46.47%	49.42%	48.42%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.09%	59.91%	59.49%	56.93%	60.36%	61.31%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	89.58%	77.65%	90.28%	92.21%	84.46%	90.75%
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	55.32%	65.96%	61.11%	60.83%	73.29%	50.36%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	50.22%	55.20%†	56.19%	46.96%	52.26%†	53.37%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.84%	34.16%†	32.16%	24.14%	31.73%†	32.81%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	53.16%	52.07%	62.50%	57.18%	62.99%	59.12%
Objective 4.2:	Increase timeliness of prenatal care.	75.41%	72.79%	83.33%	73.97%	79.86%	72.75%

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	56.44%	57.10%	62.50%	52.07%	56.21%	60.83%
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	17.80%	14.23%	5.56%	14.60%	15.33%	11.19%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	36.68%	43.01%†	43.51%	46.65%	51.99%†	43.68%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	40.91%	46.82%†	64.91%	58.02%	62.22%†	49.28%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	0.00%	***	3.74%	1.80%	1.62%†	2.26%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge.	*N/A	Complete	Complete	*N/A	Complete	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	52.99%	57.72%	79.81%	56.51%	53.64%	79.16%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	64.55%	66.83%	84.98%	69.41%	70.20%	84.20%

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

Green shading indicates the QISMC goal was met.

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

*** Indicates that QISMC goal could not be established based on prior performance.

*N/A indicates that the PIP had not progressed to the measurement stage at the time of this report.

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

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

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	98.73%	96.25%	98.18%	99.48%	95.23%	98.50%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	89.53%	91.43%	89.45%	89.55%	88.48%	89.61%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.91%	93.36%	91.83%	93.54%	94.45%	92.98%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	88.95%	92.96%	91.08%	90.78%	91.71%	91.29%
Objective 1.2:	Increase well-child visits (0–15 months).	78.05%	73.33%	78.92%	68.00%	64.00%	63.49%
Objective 1.3:	Increase well-child visits (3–6 years).	70.28%	74.17%	76.16%	70.13%	74.76%	67.64%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	62.04%	65.84%†	71.30%	72.02%	74.82%†	73.24%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	55.56%	60.00%†	65.28%	60.34%	64.31%†	61.07%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	47.69%	52.92%†	59.72%	57.18%	61.46%†	58.39%
Objective 1.5:	Increase immunizations for adolescents.	81.61%	83.45%†	83.61%	87.35%	88.62%†	87.59%
Objective 1.6:	Increase annual dental visits for children.	67.05%	68.03%	67.81%	70.11%	72.55%	68.88%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	34.11%	40.70%†	R*	42.62%	48.36%†	R*
Objective 1.8:	Increase adolescent well-care visits.	56.34%	60.83%	60.88%	52.83%	59.92%	54.74%

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.9a:	Increase childhood immunization status (Combination 2).	85.90%	77.10%	91.16%	87.93%	85.11%	84.38%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	78.21%	76.28%	82.87%	84.48%	79.45%	82.14%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	77.56%	76.28%	81.22%	83.91%	78.74%	82.14%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	68.59%	59.10%	72.93%	79.89%	69.53%	71.88%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	46.79%	50.91%	47.51%	52.30%	53.23%	41.52%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	67.95%	59.10%	72.38%	79.31%	68.82%	71.88%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	46.79%	50.91%	47.51%	51.72%	52.52%	41.52%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	42.95%	39.46%	44.75%	50.00%	48.27%	37.50%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	42.95%	39.46%	44.75%	49.43%	47.56%	37.50%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	—	—	—	—	—	—
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	—	—	—	—	—	—
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	—	—	—	—	—	—
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	—	—	—	—	—	—
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	47.76%	52.98%†	58.43%	47.62%	52.86%†	51.02%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.87%	34.18%†	24.72%	26.98%	34.28%†	27.89%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	—	—	—	—	—	—
Objective 4.2:	Increase timeliness of prenatal care.	—	—	—	—	—	—
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	—	—	—	—	—	—
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members with Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	NR	NC	41.67%	39.53%	45.58%†	48.89%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	NR	NC	NR	NR	NC	NR
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	NR	NC	NR	NR	NC	NR
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	Complete	*N/A	*N/A	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	84.85%	86.37%†	82.50%	NR	NC	NR
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	93.94%	94.55%†	97.50%	NR	NC	NR

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

Green shading indicates the QISMC goal was met.

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

*N/A indicates that a rate was not available as the PIP has not progressed to the measurement stage at the time of this report.

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

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

NR indicates that no rate was reported.

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

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

Attachment B

QAPI Goals and Objectives Tracking Table

As referenced in Section V, 2.1.3.5 and Section V, 2.1.3.6.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	94.15%	92.03%	93.83%	94.80%	92.28%	95.17%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	83.55%	83.17%	82.25%	84.29%	81.32%	83.81%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	87.12%	87.04%	86.59%	87.36%	85.54%	87.57%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	83.76%	83.38%	82.95%	85.21%	82.72%	85.51%
Objective 1.2:	Increase well-child visits (0–15 months).	52.78%	55.52%	62.50%	53.77%	56.42%	62.77%
Objective 1.3:	Increase well-child visits (3–6 years).	66.33%	69.09%	68.72%	64.48%	64.75%	65.21%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	64.12%	67.71%†	70.14%	70.32%	73.29%†	71.78%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	54.40%	58.96%†	62.73%	57.91%	62.12%†	62.29%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	43.75%	49.38%†	56.48%	52.07%	56.86%†	59.61%
Objective 1.5:	Increase immunizations for adolescents.	71.93%	74.74%†	79.40%	79.81%	81.83%†	80.78%
Objective 1.6:	Increase annual dental visits for children.	53.21%	51.06%	51.63%	55.03%	56.01%	53.85%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	24.59%	32.13%†	R*	29.68%	36.71%†	R*

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.8:	Increase adolescent well-care visits.	38.43%	47.92%	47.69%	44.04%	43.72%	44.77%
Objective 1.9a:	Increase childhood immunization status (Combination 2).	73.15%	69.58%	72.92%	74.94%	73.72%	73.72%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	66.67%	64.79%	67.13%	70.32%	69.56%	71.05%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	65.28%	62.92%	66.67%	70.07%	69.56%	71.05%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	57.18%	55.21%	56.71%	55.72%	57.74%	61.07%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	32.41%	40.00%	36.11%	38.44%	45.48%	34.79%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	56.48%	53.54%	56.25%	55.72%	57.74%	61.07%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	32.41%	39.79%	36.11%	38.44%	45.48%	34.79%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	29.63%	35.42%	32.18%	31.14%	39.12%	30.41%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	29.63%	35.21%	32.18%	31.14%	39.12%	30.41%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	79.63%	83.71%	81.02%	85.64%	85.76%	82.73%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.76%	41.76%	46.30%	45.74%	40.08%	42.82%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	46.30%	48.84%	45.60%	46.47%	49.42%	48.42%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.09%	59.91%	59.49%	56.93%	60.36%	61.31%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	89.58%	77.65%	90.28%	92.21%	84.46%	90.75%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	55.32%	65.96%	61.11%	60.83%	73.29%	50.36%
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	50.22%	55.20%†	56.19%	46.96%	52.26%†	53.37%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.84%	34.16%†	32.16%	24.14%	31.73%†	32.81%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	53.16%	52.07%	62.50%	57.18%	62.99%	59.12%
Objective 4.2:	Increase timeliness of prenatal care.	75.41%	72.79%	83.33%	73.97%	79.86%	72.75%
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	56.44%	57.10%	62.50%	52.07%	56.21%	60.83%
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	17.80%	14.23%	5.56%	14.60%	15.33%	11.19%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	36.68%	43.01%†	43.51%	46.65%	51.99%†	43.68%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	40.91%	46.82%†	64.91%	58.02%	62.22%†	49.28%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	0.00%	***	3.74%	1.80%	1.62%†	2.26%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge.	*N/A	Complete	Complete	*N/A	Complete	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	52.99%	57.72%	79.81%	56.51%	53.64%	79.16%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	64.55%	66.83%	84.98%	69.41%	70.20%	84.20%

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

Green shading indicates the QISMC goal was met.

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

*** Indicates that QISMC goal could not be established based on prior performance.

*N/A indicates that the PIP had not progressed to the measurement stage at the time of this report.

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

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

R* Indicates that NCQA retired the indicator.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	98.73%	96.25%	98.18%	99.48%	95.23%	98.50%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	89.53%	91.43%	89.45%	89.55%	88.48%	89.61%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.91%	93.36%	91.83%	93.54%	94.45%	92.98%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	88.95%	92.96%	91.08%	90.78%	91.71%	91.29%
Objective 1.2:	Increase well-child visits (0–15 months).	78.05%	73.33%	78.92%	68.00%	64.00%	63.49%
Objective 1.3:	Increase well-child visits (3–6 years).	70.28%	74.17%	76.16%	70.13%	74.76%	67.64%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	62.04%	65.84%†	71.30%	72.02%	74.82%†	73.24%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	55.56%	60.00%†	65.28%	60.34%	64.31%†	61.07%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	47.69%	52.92%†	59.72%	57.18%	61.46%†	58.39%
Objective 1.5:	Increase immunizations for adolescents.	81.61%	83.45%†	83.61%	87.35%	88.62%†	87.59%
Objective 1.6:	Increase annual dental visits for children.	67.05%	68.03%	67.81%	70.11%	72.55%	68.88%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	34.11%	40.70%†	R*	42.62%	48.36%†	R*
Objective 1.8:	Increase adolescent well-care visits.	56.34%	60.83%	60.88%	52.83%	59.92%	54.74%

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.9a:	Increase childhood immunization status (Combination 2).	85.90%	77.10%	91.16%	87.93%	85.11%	84.38%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	78.21%	76.28%	82.87%	84.48%	79.45%	82.14%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	77.56%	76.28%	81.22%	83.91%	78.74%	82.14%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	68.59%	59.10%	72.93%	79.89%	69.53%	71.88%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	46.79%	50.91%	47.51%	52.30%	53.23%	41.52%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	67.95%	59.10%	72.38%	79.31%	68.82%	71.88%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	46.79%	50.91%	47.51%	51.72%	52.52%	41.52%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	42.95%	39.46%	44.75%	50.00%	48.27%	37.50%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	42.95%	39.46%	44.75%	49.43%	47.56%	37.50%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	—	—	—	—	—	—
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	—	—	—	—	—	—
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	—	—	—	—	—	—
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	—	—	—	—	—	—
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	47.76%	52.98%†	58.43%	47.62%	52.86%†	51.02%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.87%	34.18%†	24.72%	26.98%	34.28%†	27.89%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	—	—	—	—	—	—
Objective 4.2:	Increase timeliness of prenatal care.	—	—	—	—	—	—
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	—	—	—	—	—	—
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members with Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	NR	NC	41.67%	39.53%	45.58%†	48.89%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	NR	NC	NR	NR	NC	NR
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	NR	NC	NR	NR	NC	NR
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	Complete	*N/A	*N/A	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	84.85%	86.37%†	82.50%	NR	NC	NR
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	93.94%	94.55%†	97.50%	NR	NC	NR

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

Green shading indicates the QISMC goal was met.

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

*N/A indicates that a rate was not available as the PIP has not progressed to the measurement stage at the time of this report.

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

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

NR indicates that no rate was reported.

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

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

R* Indicates that NCQA retired the indicator.

Attachment C

EXTERNAL QUALITY REVIEW TECHNICAL REPORT

As referenced in Section V, 2.1.3.5 and Section V, 2.1.3.6.

Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2016–2017 External Quality Review Technical Report

October 2017

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

1. Executive Summary

Overview of the SFY 2015–2016 External Quality Review

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

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

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2016–2017 external quality review (EQR) were **Amerigroup Nevada, Inc.** (**Amerigroup**), and **Health Plan of Nevada** (**HPN**), which operate in both Clark and Washoe counties. Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in Medicaid. Since the majority of persons in the newly eligible population reside in managed care catchment areas, many persons eligible as a result of Medicaid expansion have enrolled with one of the two MCOs offered in the Nevada Medicaid managed care program. The expansion of enrollment was much higher than the DHCFP originally anticipated. In June 2013, enrollment in managed care was 193,455 and in June 2017, enrollment in managed care was 478,040, which is a 147 percent increase.

The SFY 2016–2017 EQR Technical Report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, CHIP. The report focuses on three EQR activities, which were federally required during the time period. As described in 42 CFR §438.358, these activities are:

- Compliance monitoring evaluation.
- Validation of performance measures.
- Validation of performance improvement projects (PIPs).

In addition to the mandatory activities, HSAG performed the following activities at the request of the DHCFP:

- Evaluated the State's quality strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's quality strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). HSAG's technical assistance activities included:
  - Evaluating the HCGP Quality Strategy and developing a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  - Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
- Performed performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 8.

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

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

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

Lastly, consistent with 42 CFR §438.364(a)(6), HSAG has included in Section 9 of this report an assessment of the degree to which each MCO has effectively addressed recommendations for quality improvement that HSAG made in the previous year.

Internal Quality Assurance Program (IQAP)

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada and all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 technical report.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

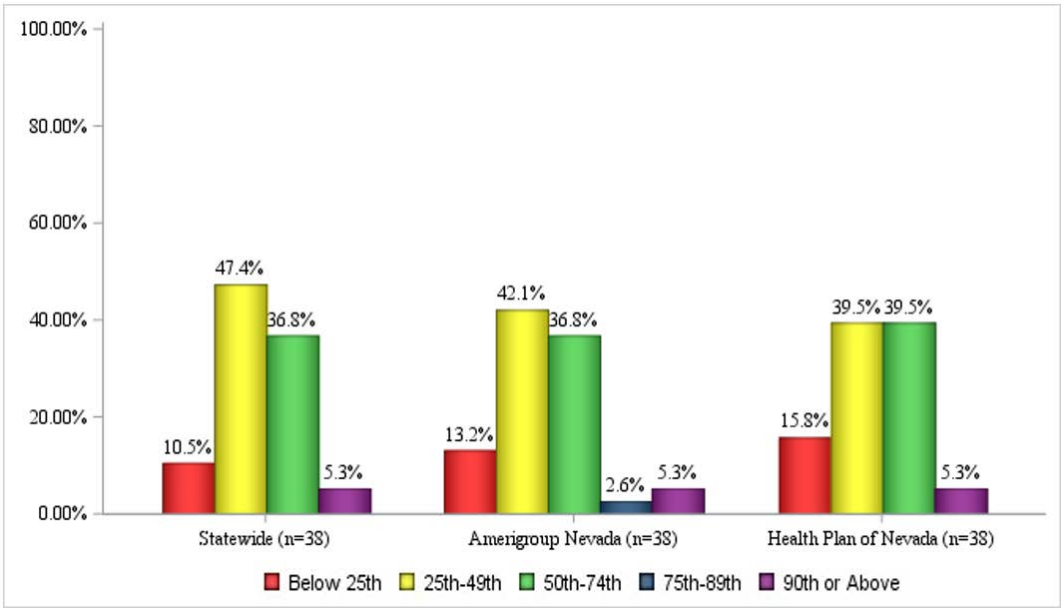
HSAG conducted an NCQA HEDIS Compliance Audit to assess **Amerigroup** and **HPN** performance with respect to the *HEDIS 2017 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. For HEDIS 2017, the MCOs were required to report 17 measures yielding a total of 45 rates for the Medicaid population and 14 measures yielding a total of 35 rates for the Nevada Check Up population. HSAG validated all measures reported by the MCOs.

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

Medicaid Findings

Figure 1-1 shows the percentage of Medicaid population rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** compared to NCQA's Quality Compass® national Medicaid HMO percentiles for HEDIS 2016.[1-1]

Figure 1-1—Percentage of HEDIS 2017 Performance Measures Rates for Medicaid Population Compared to HEDIS National Medicaid Percentiles



Note: Percentages may not total 100 percent due to rounding.

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

For HEDIS 2017, approximately 55 percent of the MCOs' rates fell below the national Medicaid 50th percentile, which represented an improvement from HEDIS 2016 when approximately 85 percent of **Amerigroup**'s rates and 67 percent of **HPN**'s rates fell below the national Medicaid 50th percentile. As a result, approximately 45 percent of the MCOs' HEDIS 2017 rates ranked at or above the national Medicaid 50th percentile compared to HEDIS 2016, when only about 15 percent of **Amerigroup**'s rates and 33 percent of **HPN**'s rates ranked at or above the national Medicaid 50th percentile. However, most of the MCOs' HEDIS 2017 rates fell at or above the national Medicaid 25th percentile but below the 75th percentile, indicating continued opportunities for improvement with regard to national benchmark comparisons.

Table 1–1 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on rate comparisons to the Quality Compass national Medicaid percentiles for HEDIS 2016. Measure results were compared to benchmarks and rated using the following star ratings:

Table 1–1—HEDIS Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

Table 1–2—HEDIS 2017 Results for Medicaid

HEDIS Measure	AGP	HPN	Medicaid
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	93.83% ★★	95.17% ★★	94.55% ★★
Ages 25 Months–6 Years	82.25% ★	83.81% ★	83.08% ★
Ages 7–11 Years	86.59% ★	87.57% ★	87.16% ★
Ages 12–19 Years	82.95% ★	85.51% ★	84.54% ★
Annual Dental Visit (ADV)			
Total	51.63% ★★	53.85% ★★★	52.91% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	47.69% ★★	44.77% ★★	45.88% ★★
Childhood Immunization Status (CIS)			
Combination 2	72.92% ★★	73.72% ★★	73.33% ★★
Combination 3	67.13% ★★	71.05% ★★	69.12% ★★
Combination 4	66.67% ★★	71.05% ★★★	68.90% ★★★
Combination 5	56.71% ★★	61.07% ★★★	58.93% ★★
Combination 6	36.11% ★★	34.79% ★★	35.44% ★★
Combination 7	56.25% ★★	61.07% ★★★	58.71% ★★★
Combination 8	36.11% ★★	34.79% ★★	35.44% ★★
Combination 9	32.18% ★★	30.41% ★★	31.28% ★★
Combination 10	32.18% ★★	30.41% ★★	31.28% ★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	79.40% ★★★	80.78% ★★★	80.25% ★★★
Combination 2 (Meningococcal, Tdap, HPV)	26.85% NC	27.49% NC	27.25% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	62.50% ★★★	62.77% ★★★	62.64% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.72% ★★	65.21% ★★	66.85% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	70.14% ★★★	71.78% ★★★	71.10% ★★★
Counseling for Nutrition—Total	62.73% ★★★	62.29% ★★	62.47% ★★
Counseling for Physical Activity—Total	56.48% ★★★	59.61% ★★★	58.31% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Maternity Care			
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	83.33% ★★★	72.75% ★	77.85% ★★
Postpartum Care	62.50% ★★★	59.12% ★★	60.75% ★★
Frequency of Ongoing Prenatal Care (FPC)			
*<21 Percent of Expected Visits**	5.56% ★★★	11.19% ★★	8.47% ★★
≥81 Percent of Expected Visits	62.50% ★★★	60.83% ★★★	61.63% ★★★
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)			
Hemoglobin A1c (HbA1c) Testing	81.02% ★	82.73% ★	82.10% ★
*HbA1c Poor Control (>9.0%)**	46.30% ★★	42.82% ★★★	44.10% ★★
HbA1c Control (<8.0%)	45.60% ★★	48.42% ★★★	47.38% ★★★
Eye Exam (Retinal) Performed	59.49% ★★★	61.31% ★★★	60.64% ★★★
Medical Attention for Nephropathy	90.28% ★★	90.75% ★★★	90.58% ★★★
Blood Pressure Control (<140/90 mm Hg)	61.11% ★★★	50.36% ★	54.33% ★★
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	56.19% ★★★	53.37% ★★	54.52% ★★
Medication Compliance 75%—Total	32.16% ★★★	32.81% ★★★	32.54% ★★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	79.81% ★★★★★	79.16% ★★★★★	79.52% ★★★★★
30-Day Follow-Up	84.98% ★★★★★	84.20% ★★★★★	84.63% ★★★★★

HEDIS Measure	AGP	HPN	Medicaid
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD)			
Initiation Phase	43.51% ★★★	43.68% ★★★	43.60% ★★★
Continuation and Maintenance Phase	64.91% ★★★★	49.28% ★★	56.35% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,]*			
Total	3.74% ★	2.26% ★★	2.92% ★★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
Any Service (Total)	8.63% NC	6.80% NC	7.57% NC
Inpatient (Total)	1.16% NC	0.78% NC	0.94% NC
Intensive Outpatient or Partial Hospitalization (Total)	0.24% NC	0.30% NC	0.28% NC
Outpatient, ED, or Telehealth (Total)	8.50% NC	6.73% NC	7.47% NC
Ambulatory Care (AMB)—Total			
Outpatient Visits—Total	287.09 NC	298.12 NC	293.47 NC
*ED Visits—Total**	54.02 NC	52.60 NC	53.20 NC

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

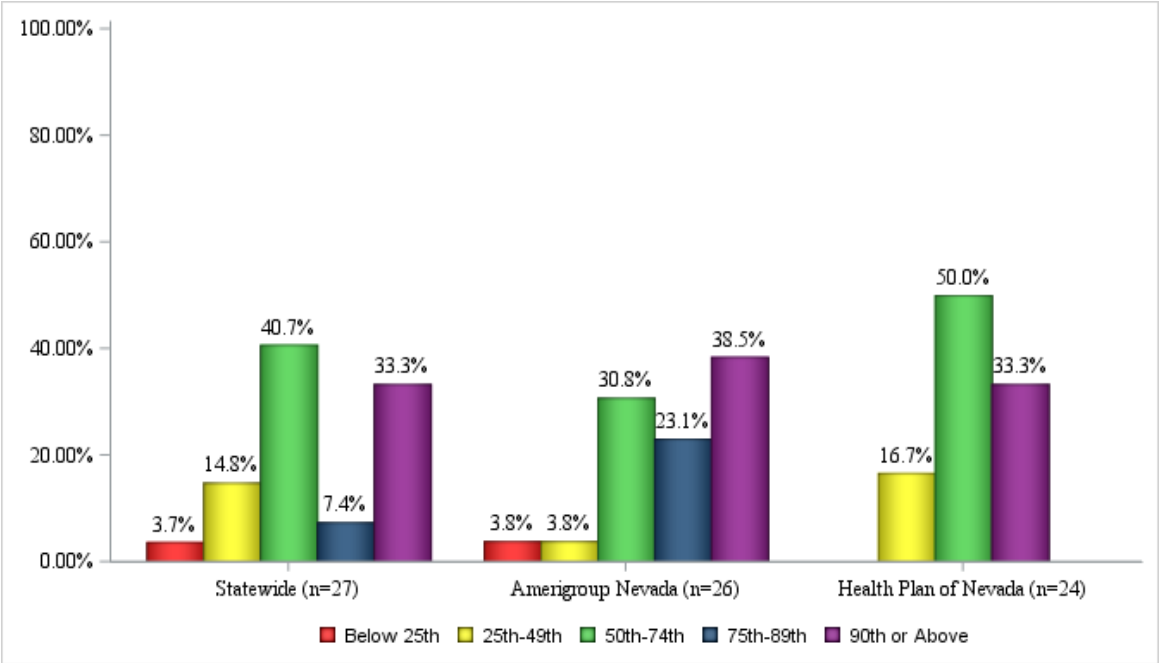
NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

Amerigroup's and **HPN**'s HEDIS 2017 rates for the Medicaid population indicate positive performance related to timely follow-up care for members hospitalized for mental illness, but there are areas for improvement related to access to care for children and adolescents, and appropriate HbA1c testing for members with diabetes. Additionally, **HPN**'s rates present opportunities for improved prenatal care timeliness for pregnant women, blood pressure control for members with diabetes, and follow-up care for children on ADHD medication.

Nevada Check Up Findings

Figure 1-2 shows the percentage of Nevada Check Up population rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016.[1-2]

Figure 1-2—Percentage of HEDIS 2017 Performance Measures Rates for Nevada Check Up Population Compared to HEDIS Medicaid National Percentiles



Note: Percentages may not total 100 percent due to rounding.

For HEDIS 2017, approximately 92 percent of **Amerigroup**'s rates ranked at or above the national Medicaid 50th percentile, which represented an improvement from HEDIS 2016 when approximately 73 percent of its rates reached this percentile ranking. Most notably, from HEDIS 2016 to 2017 the number of rates that ranked approximately between the national Medicaid 50th and 75th percentiles increased from about 23 percent to almost 31 percent, and the number of rates ranking at or above the national Medicaid 90th percentile increased from about 31 percent to approximately 39 percent. Further, the number of **Amerigroup**'s rates that fell below the national Medicaid 50th percentile decreased from approximately 27 percent for HEDIS 2016 to about only 8 percent for HEDIS 2017.

Percentile rankings for **HPN**'s rates shifted downward from 48 percent of its HEDIS 2016 rates ranking approximately between the national Medicaid 50th and 90th percentiles to 50 percent of its HEDIS 2017 rates ranking approximately between the national Medicaid 50th and 75th percentiles. Shifts in the

[1-2] Because national benchmarks for HEDIS measures are not available for the CHIP population, comparisons of Nevada's Check Up population rates to the national Medicaid percentiles should be interpreted with caution.

national benchmark comparisons indicate opportunities for **HPN** to focus efforts on determining root causes linked to declines in performance.

Table 1–3 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.

Table 1–3—HEDIS 2017 Results for Nevada Check Up

HEDIS Measure	AGP	HPN	NV Check Up
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	98.18% ★★★★★	98.50% ★★★★★	98.36% ★★★★★
Ages 25 Months–6 Years	89.45% ★★★	89.61% ★★★	89.54% ★★★
Ages 7–11 Years	91.83% ★★★	92.98% ★★★	92.55% ★★★
Ages 12–19 Years	91.08% ★★★	91.29% ★★★	91.22% ★★★
Annual Dental Visit (ADV)			
Total	67.81% ★★★★★	68.88% ★★★★★	68.48% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	60.88% ★★★★	54.74% ★★★	56.79% ★★★
Childhood Immunization Status (CIS)			
Combination 2	91.16% ★★★★★	84.38% ★★★★★	87.39% ★★★★★
Combination 3	82.87% ★★★★★	82.14% ★★★★★	82.47% ★★★★★
Combination 4	81.22% ★★★★★	82.14% ★★★★★	81.73% ★★★★★
Combination 5	72.93% ★★★★★	71.88% ★★★★★	72.34% ★★★★★
Combination 6	47.51% ★★★★	41.52% ★★★	44.18% ★★★
Combination 7	72.38% ★★★★★	71.88% ★★★★★	72.10% ★★★★★
Combination 8	47.51% ★★★★	41.52% ★★★	44.18% ★★★

HEDIS Measure	AGP	HPN	NV Check Up
Combination 9	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Combination 10	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	83.61% ★★★★	87.59% ★★★★★	86.28% ★★★★
Combination 2 (Meningococcal, Tdap, HPV)	38.46% NC	38.69% NC	38.61% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	78.92% ★★★★★	63.49% ★★★	70.70% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16% ★★★	67.64% ★★	71.34% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	71.30% ★★★	73.24% ★★★	72.52% ★★★
Counseling for Nutrition—Total	65.28% ★★★	61.07% ★★	62.61% ★★
Counseling for Physical Activity—Total	59.72% ★★★	58.39% ★★★	58.88% ★★★
Care for Chronic Conditions			
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	58.43% ★★★	51.02% ★★	53.81% ★★
Medication Compliance 75%—Total	24.72% ★	27.89% ★★	26.69% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	82.50% ★★★★★	NA	80.00% ★★★★★
30-Day Follow-Up	97.50% ★★★★★	NA	92.31% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	41.67% ★★	48.89% ★★★	45.68% ★★★
Continuation and Maintenance Phase	NA	NA	NA

HEDIS Measure	AGP	HPN	NV Check Up
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]			
Total	NA	NA	5.71% ★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
Any Service (Total)	5.68% NC	5.19% NC	5.38% NC
Inpatient (Total)	0.42% NC	0.22% NC	0.29% NC
Intensive Outpatient or Partial Hospitalization (Total)	0.16% NC	0.77% NC	0.53% NC
Outpatient, ED, or Telehealth (Total)	5.64% NC	5.18% NC	5.36% NC
Ambulatory Care (AMB)—Total			
Outpatient Visits—Total	258.30 NC	252.28 NC	254.60 NC
*ED Visits—Total**	26.30 NC	22.11 NC	23.73 NC

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

NA (i.e., Small Denominator) indicates the health plan(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup's and **HPN**'s HEDIS 2017 rates for the Nevada Check Up population indicate positive performance related to access to primary care, dental care, and immunizations for children. **Amerigroup**'s rates also demonstrate timely follow-up care for members hospitalized for mental illness. Conversely, **HPN**'s rates present improvement opportunities for access to well-child visits for infants. As mentioned above, comparisons between Nevada's Check Up population rates to national Medicaid benchmarks should be interpreted with caution.

Validation of Performance Improvement Projects (PIPs)

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed. After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS gave approval for the DHCFP to implement this new PIP approach in Nevada.

In SFY 2016–2017, the MCOs continued using the rapid-cycle PIP approach for the two DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *Behavioral Health Hospital Readmissions*. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to, care and services. Upon final validation, each PIP was given a validation score of either *High Confidence*, *Confidence*, *Low Confidence*, or *PIP Results Were Not Credible*. See Appendix A for a detailed description of PIP validation scoring.

Table 1–4—PIP Results

PIP Title	Amerigroup PIP Module Results	HPN PIP Module Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Module 4: *Achieved* Module 5: *Partially Achieved* Confidence Level: *Low confidence*	Module 4: *Achieved* Module 5: *Achieved* Confidence Level: *Confidence*
Behavioral Health Hospital Readmissions	Module 4: *Achieved* Module 5: *Partially Achieved* Confidence Level: *Low confidence*	Module 4: *Achieved* Module 5: *Partially Achieved* Confidence Level: *PIP results not credible*

Summary of Amerigroup's PIP Performance

Upon initial validation of Module 5 for **Amerigroup**'s PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, HSAG identified opportunities for **Amerigroup** to improve how it summarized the specific, measurable, attainable, relevant, and time-bound (SMART) Aim measure outcomes and findings. After receiving guidance from HSAG, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation of three components that comprised the PIP, **Amerigroup** achieved all of the Module 5

validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was only achieved for two of the three measure components. For the two components that did achieve the respective goals, **Amerigroup** is encouraged to determine the interventions that were most successful and spread those interventions to a larger population.

Upon initial validation of Module 5 for **Amerigroup**'s *Behavioral Health Hospital Readmissions* PIP, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving HSAG's guidance, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of Module 5's validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was not achieved. **Amerigroup** is encouraged to continue the PDSA cycle of improvement to test other interventions to determine if they are successful in achieving the SMART Aim goal.

Summary of HPN's PIP Performance

Upon initial validation of Module 5 for **HPN**'s PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and its documentation related to how it will sustain improvement beyond the SMART Aim end date. HSAG provided **HPN** with technical assistance to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; upon final validation, all of the validation criteria were met. Although the MCO exceeded the SMART Aim goal for all three measure components, this occurred before intervention testing and there was no clear link between the demonstrated improvement and all of the MCO's quality improvement activities. HSAG assigned a level of *Confidence* to the PIP.

Upon initial validation of Module 5 for **HPN**'s *Behavioral Health Hospital Readmission* PIP, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and the execution of the PIP methodology. HSAG provided **HPN** with technical assistance to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; however, due to **HPN** changing the top 50 super-utilizer eligible population and not executing the PIP as approved, not all validation criteria could be achieved despite the resubmission. HSAG assigned a level of *Reported PIP Results Were Not Credible* because the MCO did not execute the PIP as designed by **HPN** and approved by HSAG. **HPN** requested a rescoring of the PIP based on additional information it provided in a letter and a teleconference meeting with HSAG; however, the MCO would have been required to recreate and resubmit Modules 4 and 5 in order for HSAG to revalidate the PIP. Since the time period for resubmission had passed and SFY 2016–2017 was closed, the DHCFP advised HSAG and **HPN** to close the PIP. To initiate the new PIPs for SFY 2017–2018, HSAG's PIP team members have provided weekly technical assistance sessions to **HPN** staff members at **HPN**'s request.

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

Amerigroup

Overall, **Amerigroup** demonstrated strengths related to measures and activities that related to quality of care. Performance measures like *Immunizations for Adolescents*, *Well Child Visits in the First 15 Months of Life*, *Comprehensive Diabetes Care—Blood Pressure Control*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, which are also related to one of the MCO's PIPs, require the provider to perform the services that meet numerator compliance and properly document the services in the medical record. Over the last several years, **Amerigroup** staff members have reported an increase in provider outreach and education by **Amerigroup** clinical staff members to coach providers on proper documentation and coding in order to show numerator compliance with HEDIS measures and fill gaps in care noted by the MCO. Based on the MCO's performance, it is plausible that these interventions are having an impact. Quality-related performance measures like *Frequency of Prenatal Care* and *Medication Management for People with Asthma* all require effort on the part of the provider and the member to meet the required service and achieve numerator compliance. These measures demonstrated strong performance for **Amerigroup**.

Performance measures like *Timeliness of Prenatal Care*, *Postpartum Care*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Follow-Up After Hospitalization for Mental Illness* demonstrated strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time period to improve the efficacy of care. The quality initiatives that have been implemented, as reported by **Amerigroup** staff members during quarterly quality meetings with the DHCFP and HSAG, have included increased outreach and care management for members with mental illness so they can coordinate outpatient services upon discharge from inpatient facilities. These initiatives also have the potential to reduce behavioral health readmissions, which was one of the MCO's PIP topics. **Amerigroup** staff members also have increased education and incentives to pregnant women so they can obtain the required prenatal and postpartum care visits and also have increased incentives to providers to submit service encounters for all prenatal and postpartum service visits.

Amerigroup demonstrates opportunities for improvement related to *Children and Adolescents' Access to Primary Care Practitioners*, which falls within the access domain, as well as for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* and *Comprehensive Diabetes Care—HbA1c Testing* for members with diabetes, all of which are quality-related measures. **Amerigroup**'s CAHPS results also show opportunities for improvement based on members' perceptions of access to care and quality of the visit with the provider. For opportunities for improvement, HSAG encourages **Amerigroup** to conduct a comprehensive causal barrier analysis and apply the PDSA cycle of performance improvement to identify and test interventions that have the potential to improve performance in these areas. The approach uses resources more efficiently and implements improvement interventions that may improve performance.

HPN

Overall, **HPN** demonstrated strengths related to measures and activities that fell within the domain of quality of care. Performance measures like *Immunizations for Adolescents*, *Well Child Visits in the First 15 Months of Life*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, which are also related to one of the MCO's PIPs, require the provider to perform the services that meet numerator compliance as well as to properly document the services in the medical record. Quality-related performance measures like *Comprehensive Diabetes Care—Poor Control*, *Comprehensive Diabetes Care—HbA1c Control*, *Comprehensive Diabetes Care—Eye Exams*, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, and *Medication Management for People with Asthma* require effort from both the provider and the member to meet the required service and achieve numerator compliance. Over the last several years, **HPN** staff members have reported an increase in case management services for people with diabetes, member outreach regarding immunizations and well-child visits, and provider outreach and education by **HPN** clinical staff members to educate providers on addressing gaps in care. Based on the MCO's performance, it is plausible that these interventions are having an impact.

Performance measures like *Follow-Up Care for Children Prescribed ADHD Medication* and *Follow-Up After Hospitalization for Mental Illness* demonstrated strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time period to increase the efficacy of care. **HPN** staff members' presentations during quarterly quality meetings with the DHCFP and HSAG staff members showed that behavioral health care manager outreach to persons prior to discharge from an inpatient mental health facility was very effective in securing timely follow-up appointments after members were discharged from mental health services. These interventions have the potential to reduce behavioral health readmissions, which was one of the MCO's PIP topics.

Performance measures like *Timeliness of Prenatal Care*, *Postpartum Care*, and *Children and Adolescents' Access to Primary Care Providers*, which demonstrated opportunities for improvement, are access-related measures. According to **HPN**'s 2016 Quality Improvement Program Evaluation, initiatives like expanding the physician network to increase availability and access to care and connecting members with primary care physicians were planned for 2017. These access-related initiatives have the potential to improve accessibility to these services.

HPN demonstrates opportunities for improvement related to HbA1c testing and blood pressure control for members with diabetes, which are quality-related measures. The **HPN** 2016 Quality Improvement Program Evaluation showed an evaluation and analysis (e.g., by race and ethnicity) of comprehensive diabetes care indicators; however, HbA1c testing was not included as one of the evaluated indicators. HSAG recommends that **HPN** analyze data related to HbA1c testing as it does for other diabetes-related indicators to identify opportunities for improvement and potential disparities among the data. This will enable **HPN** to identify interventions that may be targeted to the subpopulations that have the least numerator compliance for the measure. **HPN**'s CAHPS results also showed opportunities for improvement based on members' perceptions of the quality of the visit with the provider. For all opportunities for improvement, HSAG encourages **HPN** to conduct a comprehensive causal barrier analysis and apply the PDSA cycle of performance improvement to identify and test interventions that

have the potential to improve performance in these areas. The approach uses resources more efficiently and implements improvement interventions that have the potential to improve performance.

Pay-For-Performance Opportunities for Both MCOs

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

- *Children and Adolescents Access to Primary Care Practitioners—12 Months–24 Months*
- *Children and Adolescents Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents Access to Primary Care Practitioners—12 Years–19 Years*
- *Childhood Immunization Status—Combination 10*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Frequency of Ongoing Prenatal Care—Greater than 81 Percent of Visits*

HCGP Performance Measure Validation (PMV)

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

The DHCFP sought to verify that, on an annual basis, **AxisPoint Health** (**APH**) collected and reported complete and accurate performance measure data for contractually required performance measures. To verify the accuracy of **APH**'s reported rates, the DHCFP contracted with HSAG to validate the performance measure rates that **APH** calculated and reported. To ensure that the PMV activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the EQR Protocol 2[1-3] developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jul 18, 2017.

2. Determine the extent to which the measures that **APH** calculated followed the DHCFP's specifications and reporting requirements.

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

Performance Measure Validation Findings

This audit reviewed 22 performance measures. All of the measures were determined to be reportable by **APH** for the reporting period under review; however, there were several issues identified during the on-site audit.

It was determined during the audit for the first program period (June 1, 2014, through May 30, 2015), that all of the indicators (numerators) for the *Childhood Immunization Status* measure were under-reported and based solely on administrative data. Without immunization data from the State registry or medical record review, this measure's rates were too low to derive effective conclusions. The State provided the immunization registry data to **APH** for both program periods during the second program period (June 1, 2015, through May 30, 2016). **APH** calculated the current program period immunization rates and recalculated them for the first program period. The rates for both program periods were approved.

For the *Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy (NEUR)* measure, the denominator remained low for the second program period. Members in the denominator must have been in the HCGP program the entire program period. The numerator only included members who were discharged on antithrombotic therapy.

The *Adult Kidney Disease—Laboratory Testing (CKD)* measure evaluated whether a member with kidney disease had a fasting lipid profile completed during the program year. The rate provided by **APH** was 0.00 percent. A line-by-line evaluation of the source code identified that the code aligned with the technical specifications. However, the auditor determined that the technical specifications did not include the most common CPT code (80061) used for the fasting lipid profile. During the on-site visit, **APH** recalculated the measure to determine the impact of the missing code 80061. The results of the recalculation increased the rate to more than 77 percent.

During the first program year, for the *Cognitive Assessment for Dementia (DEM)* measure **APH** was not able to fully identify the denominator. **APH** applied the State-allowed changes to the denominator code, which improved the identification of dementia. However, the numerator for this measure continued to be problematic for **APH**. Its providers were not submitting claims that incorporated the CPT code for the assessment. Since the members with dementia were identified, it is likely the majority of those members had an assessment completed.

The weight assessment body mass index (BMI) component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both age groups (3–11 and 12–18 years of age) had no administrative data and was reported as 0.0 percent. The source code appeared to use the adult BMI code set instead of the child BMI code set. During the on-site visit, **APH** corrected its source code and the new rates were considered reportable. It was also noted by the auditor that the rates produced by Milliman were low.

As identified during the first program year's audit, the rates for *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* were very low compared to national percentiles. Global billing practices may have impacted these rates. Global billing is the submission of a single claim for a fixed fee that covers all care related to a certain condition over a particular period of time, such as billing for prenatal and postpartum care visits in conjunction with the delivery. Since generally only global billing is submitted for the duration of the woman's pregnancy, performance measures could be under-reported without medical record abstraction to augment records found to be numerator-compliant. *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* rates were considered reportable since the calculation of the measures met the technical specifications, and a true under-reported bias could not be ascertained during the audit.

Overall, **APH** would benefit from conducting a rigorous evaluation of its performance as it relates to the performance measures adopted for the HCGP. It was not clear from the PMV audit or from quarterly quality meetings with **APH** whether the contractor conducts regular subgroup analyses of its quality measures to examine what might be impacting numerator noncompliance. Although DHCFP staff members have pressed the importance and educated **APH** on the need for continually evaluating data and applying quality improvement strategies to improve performance on the population overall, **APH** remains fixated on evaluating the performance on the less than 3,000 enrollees (of 39,000 enrolled) who are served through active case management. HSAG recommends that **APH** follow the expectations outlined to **APH** in the 2017 Quality Strategy Modules, which state:

> DHCFP expects that **APH** will monitor these performance measures on an ongoing basis and calculate the rates regularly to determine if any of the interventions used by **APH** to improve rates are having the desired effect. Further, DHCFP expects that **APH** will apply a continuous quality improvement approach and conduct barrier analyses on performance measure rates that appear to be stagnant or have declined over time.

2. Overview of Nevada Managed Care Program

Nevada State Managed Care Program

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

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

In 2002, contracts were procured again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contracts when Medicaid procured them again in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2012, the DHCFP re-procured the managed care contracts, with services to begin July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the MCOs in Clark and Washoe counties through June 30, 2017. This report displays the results from the external quality review (EQR) activities performed during SFY 2016–2017.

The State of Nevada managed care program requires the enrollment of recipients found eligible for Medicaid coverage under the family medical coverage (FMC). Applications for medical assistance under the modified adjusted gross income (MAGI) medical eligibility group includes the following aid categories:

- AM—Parents and Caretakers
- AM1—Expanded Parent and Caretakers
- CH—Poverty Level Children and Pregnant Women
- CH1—Expanded Children's Group Ages 6–18 Years
- CH5—Omnibus Budget Reconciliation Act (OBRA)
- CA—Childless Adults, Without Dependents, Ages 19–64 Years
- TR—Transitional Medicaid
- PM—Post Medical
- NC—Nevada Check Up–State CHIP Program for Children Under 19 Years

The managed care program allows voluntary enrollment for the following recipients (these categories of enrollees are not subject to mandatory lock-in enrollment provisions):

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

Demographics of Nevada State Managed Care Program

The Division of Welfare and Supportive Services carries out the eligibility and aid code determination functions for the Medicaid and Nevada Check Up applicant and eligible population. In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment compared to prior years. For example, in June 2013, enrollment in managed care was 193,455 and in June 2017, enrollment in managed care was 478,040, which is a 147 percent increase.

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients as of June 2017. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

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

Gender/Age Band	June 2017 Members
Males and Females <1 Year of Age	18,740
Males and Females 1–2 Years of Age	29,909
Males and Females 3–14 Years of Age	144,901
Females 15–18 Years of Age	16,477
Males 15–18 Years of Age	16,242
Females 19–34 Years of Age	69,538
Males 19–34 Years of Age	40,964
Females 35+ Years of Age	65,222
Males 35+ Years of Age	53,087
Total Medicaid	**455,080**

Gender/Age Band	June 2017 Members
Males and Females <1 Year of Age	155
Males and Females 1–2 Years of Age	1,456
Males and Females 3–14 Years of Age	16,541
Females 15–18 Years of Age	2,388
Males 15–18 Years of Age	2,420
Total CHIP	**22,960**
Total Medicaid and CHIP	**478,040**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2017.

Table 2-2—June 2017 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	232,673	34,223
Amerigroup	164,771	23,413
Total	**397,444**	**57,636**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2017.

Table 2-3—June 2017 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	11,397	2,698
Amerigroup	7,402	1,463
Total	**18,799**	**4,161**

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2017.

Table 2-4—June 2017 Nevada MCO Medicaid Ethnic Composition

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	14,852	1,518
Black Non-Hispanic	98,002	3,284
Hispanic	36	20

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Am Indian/Alaskan Non-Hispanic	1,348	661
Am Indian/Alaskan and White	414	121
Asian and White	1,183	222
Black African Am and White	3,284	428
Am Indian/Alaskan and Black	969	106
Other Non-Hispanic	34,013	3,392
Asian/Pacific Islander Hispanic	937	167
Black Hispanic	1,788	125
Am Indian/Alaskan Hispanic	215	44
White Hispanic	132,576	19,038
White Non-Hispanic	107,729	28,608
Total	**397,346**	**57,734**

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2017.

Table 2-5—June 2017 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	769	82
Black Non-Hispanic	1,897	63
Hispanic	2	1
Am Indian/Alaskan Non-Hispanic	35	51
Am Indian/Alaskan and White	17	6
Asian and White	82	19
Black African Am and White	113	16
Am Indian/Alaskan and Black	63	6
Other Non-Hispanic	1,759	272
Asian/Pacific Islander Hispanic	55	18
Black Hispanic	75	3
Am Indian/Alaskan Hispanic	17	7
White Hispanic	10,387	2,546
White Non-Hispanic	3,568	1,031
Total	**18,839**	**4,121**

Network Capacity Analysis

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

Nevada State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of health care services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and prepaid inpatient health plans must meet. This section outlines the goals and objectives of the DHCFP 2016–2017 Quality Strategy as well as the annual evaluation of the strategy for SFY 2016–2017.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the growth of health care costs, and to review Medicaid and other State health care programs to determine the potential to maximize federal revenue opportunities. The Nevada Department of Health and Human Services (DHHS) director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's 2016–2017 Quality Strategy is to:

- Establish a comprehensive quality improvement system that was consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system.

The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.

- Identify opportunities to improve the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up recipients have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the state government.
- Improve recipient satisfaction with care and services.

Consistent with the national quality strategy, the DHCFP established the following quality goals for the 2016–2017 Quality Strategy to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to increase rates by 10 percent.

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

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

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

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

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

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

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

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

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

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

Objective 1.5: Increase immunizations for adolescents.

Objective 1.6: Increase annual dental visits for children.

Objective 1.7: Increase human papillomavirus vaccine for female adolescents.[2-1]

Objective 1.8: Increase adolescent well-care visits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 4.1: Increase the rate of postpartum visits.

[2-1] NCQA retired this measure in 2016; therefore, no rates.

Objective 4.2: Increase timeliness of prenatal care.

Objective 4.3: Increase frequency of prenatal care visits (≥ 81 percent of visits).

Objective 4.4: Increase frequency of prenatal care visits (<21 percent of visits).**

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

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

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

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

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

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

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

Goal 6: Increase reporting of CMS quality measures.

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

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

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

To establish performance targets, the DHCFP uses a QISMC methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate is 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points, to 59.5 percent. This is calculated as 4.5%= 10% x (100% – 5%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

To view the State's most recent version of the quality strategy, please see go to the quality strategy link located at: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2016-17_QAPIS_Report_F1.pdf.

Annual Quality Strategy Evaluation

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

the goals. SFY 2014–2015 marked the baseline year of measurement for the 2016–2017 Quality Strategy goals and objectives and also established the QISMC goal for each of the objectives.

Table 2-6 shows the MCOs' achievement of goals and objectives in SFY 2016–2017. HSAG updates the tracking table annually and produce the results in each year's annual EQR technical report. For additional detail, please see Appendix B of this report.

Table 2-6—2016–2017 Quality Strategy Goals and Objectives Summary of Achievement by MCO*

Metric	Amerigroup Medicaid	Amerigroup Check Up	HPN Medicaid	HPN Check Up
Number of Comparable Rates (Year 1 to Year 2)	41	28	41	27
Number of Rates That Improved	28/41 (68%)	20/28 (71%)	24/41 (59%)	10/27 (37%)
Number of Rates That Stayed the Same	3/41 (7%)	3/28 (11%)	3/41 (7%)	3/27 (11%)
Number of Rates That Achieved QISMC Goal	25/41 (61%)	20/28 (71%)	25/41 (61%)	10/27 (37%)
Number of Rates That Declined	10/41 (24%)	5/28 (18%)	14/41 (34%)	14/27 (52%)

* Note: This table denotes changes in rates from SFY 2015–2016 to SFY 2016–2017 only and does not indicate that changes are statistically significant.

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

Annual Health Care Guidance Program (HCGP) Quality Strategy Evaluation

The DHCFP requested that HSAG complete performance measure validation of program Year 2 non-P4P rates, which will be final after this report is due. HSAG will provide the results of the HCGP Quality Strategy evaluation in the SFY 2017–2018 EQR Technical Report.

Quality Initiatives and Emerging Practices

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

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which health plan performance is measured.

MCO-Specific Quality Initiatives

Listed below is a sampling of the strategic quality initiatives the health plans employ to improve performance health outcomes.

HPN

HPN highlighted the following strategic quality initiatives as priorities for calendar year 2016:

- **Citibank Initiative**: Incentivizes members to complete visit(s) and screenings within appropriate time frame to receive Citibank gift card.
- **Teddy Bear Transfer Program**: Encourages the use of the Southwest Medical Associates (SMA) pediatric clinics for acute and routine care vs. urgent or convenient cares. SMA staff members assist families with obtaining care from the nearest pediatric clinic instead of an urgent care facility for non-urgent care needs. This allows the patient and family to establish a relationship with a primary care physician so that the patient and family may obtain primary care appropriately. Every attempt is made to get a child to a pediatrician; however, if one is not available, urgent care may be accessed to complete the visit.
- **Urgent Care Visits with SMA**: Includes urgent care visits for SMA members. A member's primary care physician may access the medical records by being a participant in the medical home.
- **Extended Pediatric Clinic Hours**: Includes extended hours to 6:45 p.m. at three SMA clinics on Tuesdays, Wednesdays, and Thursdays.

- **HEDIS Nurses Conducted Clinic Visits**: Includes site visits to pediatric clinics for Medicaid members. Nurses discussed necessary documentation elements, provided tools for the providers, and assisted with template development.
- **Provider Education**: Provides education to providers on how to turn a sick visit into a well-child visit.
- **Covered Sports Physicals**: Educate providers on using sports physicals to provide well-child services as well.
- **Distributes Provider Resource Sheets** that included the timeline, documentation elements, and tasks that would be considered a missed opportunity for pediatric and adult HEDIS measures so that providers have a better opportunity to ensure the documentation is correct and receive full credit for the visit.
- **Care For Me Program (CFMP)** provides high-touch case management services and care coordination with a single point of contact for hospital discharges and outpatient members in all clinics. The case manager works in collaboration with members, providers, and key stakeholders in coordinating healthcare services and referrals.
- **Provides Gaps in Care Reports** to provider groups on a monthly basis to show where gaps in care exist.

Amerigroup

Amerigroup highlighted the following strategic quality initiatives as priorities for calendar year 2016:

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Annual Birthday Reminders**: Member receives a birthday mailer during his or her birth month to seek the relevant services according to the member's age and gender. Adults are sent an annual wellness visit reminder.
- **EPSDT Monthly Reminder of Overdue Services**: Members who are 90 days past-due for specific EPSDT services receive a reminder mailer to complete relevant services.
- **EPSDT Physician Monthly Reminder Overdue Services**: PCP receives a report of assigned members who are overdue for EPSDT services.
- **Member Reminder Program through VOXIVA**: Members receive interactive automated voice response calls from VOXIVA, a health and wellness company, to remind members of important health information and required screenings.
- **My Wellness Guide**: Members have access to a smart phone-based member engagement solution managed by Medicaid Digital Solutions, which tracks fitness activities for members.
- **Incentives**: Member and provider incentive programs continue.
- **Pursuant Health**: Members use kiosks at Walmart, Safeway, and other retail venues to complete health risk assessments or obtain flu shots. Members receive incentives by scanning the receipt from the activity they completed at the kiosk. The incentive can be used immediately in the store. The service allows blood pressure checks, body mass index and weight management, smoking cessation, and stress management assessments, and members may stay engaged through email, text, and digital ads.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 CFR §438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In SFY 2016–2017, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2014–2015 initiated a new three-year review cycle of Internal Quality Assurance Program review of compliance. SFY 2015–2016 was the second year of the cycle. In SFY 2015–2016, HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. SFY 2016–2017 was the third year of the three-year cycle during which HSAG worked with the DHCFP to plan the next cycle of reviews that will begin in SFY 2017–2018.
- **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, the MCOs.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional Activities

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

- Evaluated the State's Quality Strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's Quality Strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, which is the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver that was approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). HSAG's technical assistance activities included:

- Evaluating the HCGP Quality Strategy, which was developed in response to the requirements included in the 1115 Research and Demonstration Waiver special terms and conditions.
- Participating in quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. HSAG also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
- Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which are calculated by the DHCFP's actuary.
- Performing a performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 8.

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

4. Internal Quality Assurance Program (IQAP) Review—SFY 2016–2017

Overview

According to 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, the DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Amerigroup** and **HPN** in SFY 2014–2015, which initiated a new three-year cycle of Internal Quality Assurance Program (IQAP) Review of Compliance.

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada; all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 EQR technical report.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2016–2017

The DHCFP requires the MCOs to submit performance measurement data as part of their quality assessment and performance improvement programs for the Medicaid and Nevada Check Up populations. Validating the MCOs' performance measures is one of the federally required external quality review (EQR) activities described in 42 CFR §438.358(b)(2). To comply with this requirement, the DHCFP contracted with HSAG to validate the performance measures through NCQA HEDIS Compliance Audits. These audits focused on the ability of the MCOs to process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data accurately. As part of the audits, HSAG also explored the issue of completeness of claims and encounter data to improve rates for the performance measures.

The following section provides summary information from the NCQA HEDIS Compliance Audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2017 audits may be found in the July 2017 NCQA HEDIS Compliance Audit Final Report of Findings.

Of note, the DHCFP expanded Medicaid coverage in January 2014 to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The majority of newly eligible persons resided in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment since January 2014.

Objectives

The objectives of the NCQA HEDIS Compliance Audit were to assess the performance of the MCOs with respect to the *HEDIS 2017 Technical Specifications* and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the MCO's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; certified measure status; and any manual processes employed in HEDIS 2017 data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

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

Table 5–1 lists the required HEDIS 2017 measures for the Medicaid and Nevada Check Up populations.

Table 5–1—Required HEDIS 2017 Measures

HEDIS Measure	Medicaid Population	Nevada Check-Up Population
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners (CAP)—Ages 12–24 Months, Ages 25 Months–6 Years, Ages 7–11 Years, and *Ages 12–19 Years*	√	√
Annual Dental Visit (ADV)—Total	√	√
Children's Preventive Care		
Adolescent Well-Care Visits (AWC)—Adolescent Well-Care Visits	√	√
Childhood Immunization Status (CIS)—Combinations 2–10	√	√
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	√	√
Well-Child Visits in the First 15 Months of Life (W15)—Six or More Well-Child Visits	√	√
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	√	√
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	√	√
Maternity Care		
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	√	
Frequency of Ongoing Prenatal Care (FPC)—<21 Percent of Expected Visits and *≥81 Percent of Expected Visits*	√	
Care for Chronic Conditions		
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and *Blood Pressure Control (<140/90 mm Hg)*	√	
Medication Management for People with Asthma (MMA)—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	√	√
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up and *30-Day Follow-Up*	√	√
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	√	√
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total	√	√

HEDIS Measure	Medicaid Population	Nevada Check-Up Population
Utilization and Diversity of Membership		
Mental Health Utilization (MPT)—Any Service (Total), Inpatient (Total), Intensive Outpatient or Partial Hospitalization (Total), and *Outpatient or Emergency Department (ED) (Total)*	√	√
Ambulatory Care (AMB)—Outpatient Visits—Total and *ED Visits—Total*	√	√

Plan-Specific Findings—Amerigroup

A detailed review of the 2017 performance reports submitted by **Amerigroup** determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- **Amerigroup** was fully compliant with IS standard 1.0 and continued to receive paper and electronic claims daily. **Amerigroup**'s document management group received paper claims, entered them into the system, and sent them to Smart Data Solutions for scanning or keying. Electronic claims were received from Change Health Care, Availity, and Smart Data Solutions. Providers also had the ability to submit directly to **Amerigroup**. Excellent reconciliation processes continued in place to ensure that all transmission processes were accurate and complete. Front-end business edits were in place within **Amerigroup**'s claims processing system, Facets, to ensure accuracy of submitted claims. Accepted claims were loaded into Facets for adjudication. Facets captured all medical codes required for HEDIS reporting. There were no nonstandard codes or forms accepted during the measurement year. **Amerigroup** performed an on-site demonstration of Facets and identified the necessary edits to ensure accuracy. Accuracy results for the measurement year exceeded **Amerigroup**'s established standards and there was no backlog of processing claims during the measurement year. Financial and procedural audits were in place and reached 99 percent for the measurement year. All providers were fee-for-service, so data completeness was not a concern. Pharmacy data were received from the State's vendor, Express Scripts, during the measurement year and there were no issues with receipt of these data. Vision data were received from DentaQuest and dental data from Scion Dental. Data were tracked and trended throughout the measurement year.
- **Amerigroup** was fully compliant with IS standard 2.0. It experienced an increase in enrollment for its Medicaid and Nevada Check Up product lines. Despite the increase, there was no backlog in processing enrollment data. Files were received daily in an 834 format that included edits and updates. Error reports were reviewed and resolved within 24 hours. Accuracy results met established standards. All enrollment segments were captured and while retroactivity exists, it does not contribute to the extent where it would be considered for continuous enrollment

determination. A system demonstration was performed on-site and all fields required for HEDIS reporting were present.

- **Amerigroup** was fully compliant with IS standard 3.0. Cactus was the system that continued to be used to maintain credentialing data. Applications were received by the plan where primary source verification was conducted. **Amerigroup** maintains a Common Practitioner ID for internal tracking and uses National Provider Identifier (NPI) for claims processing. Facets was used to adjudicate claims and an automated process reconciled data between Cactus and Facets. This is an organizationally developed procedure and **Amerigroup** should consider it a best practice. There was a percentage of delegated credentialing and **Amerigroup** conducted the appropriate oversight for these providers. On-site, the Facets and Cactus systems were examined and all fields required for HEDIS reporting were present.
- **Amerigroup** was fully compliant with IS standard 4.0. HSAG reviewed **Amerigroup**'s IS 4 Roadmap pertaining to the policies and procedures for standard 4.0. The review found these policies and procedures to be consistent with the 4.0 requirements. **Amerigroup** sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. A review of provider chase logic determined it was appropriate across the hybrid measures. For HEDIS 2017, **Amerigroup** contracted with Ciox Health, LLC, (formerly known as Enterprise Consulting Solutions, Inc.) to retrieve medical records. **Amerigroup** continued to contract with Inovolan for use of its Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for HEDIS 2017. HSAG participated in a live vendor demonstration of the QSHR tool and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2017, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved QSHR's hybrid tool and instructions on January 20, 2017. **Amerigroup** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of QSHR's abstraction tools to conduct the reviews accurately. **Amerigroup** maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusion as well as a random sample of numerator negatives. HSAG reviewed and approved **Amerigroup**'s abstraction training manual on February 8, 2017.
- Due to significant changes in the measure specifications for IMA, a convenience sample was requested for *Immunizations for Adolescents—Combination 2*. The *Immunizations for Adolescents—Combination 2* records passed HSAG's review.
- **Amerigroup** passed the medical record review validation (MRRV) process for the following measure groups:
  - Group A: *Biometrics (BMI, BP) and Maternity—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - Group B: *Anticipatory Guidance and Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
  - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
  - Group D: *Immunizations and Other Screenings—Immunizations for Adolescents—Combination 2*

- **Amerigroup** was fully compliant with IS standard 5.0. **Amerigroup** presented four standard supplemental databases—EPSDT Immunization Registry, CPL, LabCorp, and Quest—which were approved to use for HEDIS 2017 reporting. Roadmap Section 5 for each database was provided and reviewed; there were no concerns with any of the data sources. On-site, data sources were examined and all required fields for HEDIS reporting were present. Supplemental data impact reports were received in accordance with final rate production. **Amerigroup** did not submit any nonstandard supplemental databases for HEDIS 2017 reporting.
- **Amerigroup** was fully compliant with IS standard 7.0. **Amerigroup** continued to use Inovolan's Quality Spectrum Insight software for HEDIS measure reporting. The software was maintained with **Amerigroup** and upgrades and patches were applied appropriately. The warehouse was examined on-site and the file structure fully supported HEDIS reporting. File transfer logs were used to monitor data integration from various sources and reconciled appropriately. There were no variances in the file transfer logs examined on-site. Primary source verification (Query 3) was conducted on-site for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure and no issues were identified. All Tier 2 and Tier 4 warnings were resolved, where applicable, before rates were finalized. All measures under the scope of the audit received a *Reportable* designation.

Medicaid Results

The Medicaid HEDIS 2015, 2016, and 2017 rates for **Amerigroup** are presented in Table 5–2, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5–2—Medicaid HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	91.14%	94.15%	93.83%	2.69
Ages 25 Months–6 Years	81.30%	83.55%	82.25%	0.95
Ages 7–11 Years	85.60%	87.12%	86.59%	0.99
Ages 12–19 Years	81.53%	83.76%	82.95%	1.42
Annual Dental Visit (ADV)				
Total	45.62%	53.21%	51.63%	6.01
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	42.13%	38.43%	47.69%	5.56
Childhood Immunization Status (CIS)				
Combination 2	66.20%	73.15%	72.92%	6.72
Combination 3	60.88%	66.67%	67.13%	6.25
Combination 4	58.80%	65.28%	66.67%	7.87
Combination 5	50.23%	57.18%	56.71%	6.48
Combination 6	33.33%	32.41%	36.11%	2.78
Combination 7	48.38%	56.48%	56.25%	7.87
Combination 8	33.10%	32.41%	36.11%	3.01
Combination 9	28.24%	29.63%	32.18%	3.94
Combination 10	28.01%	29.63%	32.18%	4.17
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	71.93%	79.40%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	26.85%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	50.58%	52.78%	62.50%	11.92

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.66%	66.33%	68.72%	3.06
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	64.12%	70.14%	NC
Counseling for Nutrition—Total	—	54.40%	62.73%	NC
Counseling for Physical Activity—Total[1]	—	43.75%	56.48%	NC
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	69.77%	75.41%	83.33%	13.56
Postpartum Care	46.74%	53.16%	62.50%	15.76
Frequency of Ongoing Prenatal Care (FPC)				
*<21 Percent of Expected Visits**	15.81%	17.80%	5.56%	-10.25
≥81 Percent of Expected Visits	52.33%	56.44%	62.50%	10.17
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)[1]				
Hemoglobin A1c (HbA1c) Testing	81.90%	79.63%	81.02%	-0.88
*HbA1c Poor Control (>9.0%)**	46.40%	46.76%	46.30%	-0.10
HbA1c Control (<8.0%)	43.16%	46.30%	45.60%	2.44
Eye Exam (Retinal) Performed	55.45%	55.09%	59.49%	4.04
Medical Attention for Nephropathy	75.17%	89.58%	90.28%	15.11
Blood Pressure Control (<140/90 mm Hg)	62.18%	55.32%	61.11%	-1.07
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	50.22%	56.19%	NC
Medication Compliance 75%—Total	—	26.84%	32.16%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	53.02%	52.99%	79.81%	26.79
30-Day Follow-Up	63.14%	64.55%	84.98%	21.84

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	36.68%	43.51%	NC
Continuation and Maintenance Phase	—	40.91%	64.91%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]				
Total	—	0.00%	3.74%	NC
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
Any Service (Total)	5.79%	7.21%	8.63%	2.84
Inpatient (Total)	0.42%	1.18%	1.16%	0.74
Intensive Outpatient or Partial Hospitalization (Total)	0.13%	0.28%	0.24%	0.11
Outpatient, ED, or Telehealth (Total)	5.67%	7.01%	8.50%	2.83
Ambulatory Care (AMB)—Total				
Outpatient Visits—Total	286.25	294.01	287.09	0.84
*ED Visits—Total**	53.27	55.08	54.02	0.75

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

Amerigroup's performance improved from HEDIS 2015 to HEDIS 2017 in several areas, including dental care and immunizations for children, well-child visits for infants, well-care visits for adolescents, prenatal and postpartum care, and timely follow-up care for members hospitalized for mental illness. The most notable increase was in *Follow-Up After Hospitalization for Mental Illness*, where the seven-day follow-up had a 26.79 percentage point increase and the 30-day follow-up had a 21.84 percentage point increase. Based on comparisons from HEDIS 2015 to HEDIS 2017, none of **Amerigroup**'s Medicaid rates demonstrated a notable decline in performance (i.e., a decline of greater than 5 percentage points between the HEDIS 2015 and 2017 rates).

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, and 2017 rates for **Amerigroup** are presented in Table 5–3, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5–3—Nevada Check Up HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	95.83%	98.73%	98.18%	2.35
Ages 25 Months–6 Years	90.48%	89.53%	89.45%	-1.03
Ages 7–11 Years	92.62%	92.91%	91.83%	-0.79
Ages 12–19 Years	92.18%	88.95%	91.08%	-1.10
Annual Dental Visit (ADV)				
Total	64.48%	67.05%	67.81%	3.33
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	56.48%	56.34%	60.88%	4.40
Childhood Immunization Status (CIS)				
Combination 2	74.55%	85.90%	91.16%	16.61
Combination 3	73.64%	78.21%	82.87%	9.23
Combination 4	73.64%	77.56%	81.22%	7.58
Combination 5	54.55%	68.59%	72.93%	18.38
Combination 6	45.45%	46.79%	47.51%	2.06
Combination 7	54.55%	67.95%	72.38%	17.83
Combination 8	45.45%	46.79%	47.51%	2.06

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Combination 9	32.73%	42.95%	44.75%	12.02
Combination 10	32.73%	42.95%	44.75%	12.02
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	81.61%	83.61%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	38.46%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	70.37%	78.05%	78.92%	8.55
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.30%	70.28%	76.16%	4.86
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	62.04%	71.30%	NC
Counseling for Nutrition—Total	—	55.56%	65.28%	NC
Counseling for Physical Activity—Total[1]	—	47.69%	59.72%	NC
Care for Chronic Conditions				
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	47.76%	58.43%	NC
Medication Compliance 75%—Total	—	26.87%	24.72%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	NA	84.85%	82.50%	NC
30-Day Follow-Up	NA	93.94%	97.50%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	41.67%	NC
Continuation and Maintenance Phase	—	NA	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]				
Total	—	NA	NA	NC

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
Any Service (Total)	4.31%	5.76%	5.68%	1.37
Inpatient (Total)	0.33%	0.46%	0.42%	0.09
Intensive Outpatient or Partial Hospitalization (Total)	0.18%	0.32%	0.16%	-0.02
Outpatient, ED, or Telehealth (Total)	4.23%	5.69%	5.64%	1.41
Ambulatory Care (AMB)—Total				
Outpatient Visits—Total	268.54	263.50	258.30	-10.24
*ED Visits—Total**	23.94	26.14	26.30	2.36

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Not Applicable due to a small denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup's performance improved from HEDIS 2015 to HEDIS 2017 in the areas of immunizations for children and well-child visits for infants. Based on comparisons from HEDIS 2015 to HEDIS 2017, none of **Amerigroup**'s Nevada Check Up rates demonstrated a notable decline in performance (i.e., a decline of greater than 5 percentage points between the HEDIS 2015 and 2017 rates).

Summary of Amerigroup Strengths

The following Medicaid performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Annual Dental Visit—Total*
- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5,* and *7*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

- *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits* and *≥81 Percent of Expected Visits*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*[5-1]
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Childhood Immunization Status—Combinations 2, 3, 4, 5, 7, 9,* and *10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Summary of Amerigroup Opportunities for Improvement

None of the Medicaid or Nevada Check Up performance measure rates for **Amerigroup** demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017.

Plan-Specific Findings—HPN

A detailed review of the 2017 performance reports submitted by **HPN** determined that the reports were prepared according to the *HEDIS 2017 Technical Specifications* for all of the audited measures, which are listed in Appendix A. Audits of IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with IS standard 1.0 for medical services data. **HPN** continued to use the Facets system for claims and encounter data processing. Only standard codes and standard forms were accepted, and data entry processes were effective and efficient and they assured timely, accurate entry into the system. **HPN** continued to increase auto-adjudication, and approximately 79 percent of the claims and encounters were auto-adjudicated. The Facets system captured the rendering provider even for claims submitted by federally qualified health centers. Most claims that **HPN** received were electronic claims (electronic data interchange [EDI]). **HPN** had appropriate procedures to receive and monitor the EDI submissions. The **HPN** staff monitored and trended volume routinely to ensure data completeness. In addition to monitoring data completeness, **HPN** had appropriate validation processes to ensure accurate claims and encounter data submission. Pharmacy data were obtained from Optum Rx, while lab data came from Quest. **HPN** also had appropriate processes in place to oversee these vendors, including review of submitted data and monitoring of contract standards. There were no issues identified with the medical services data.

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

- **HPN** was fully compliant with IS standard 2.0 for enrollment data. The enrollment data processes have been consistent for many years and there were no changes in them during 2016. **HPN** received membership data from the State's vendor and these data were fully reconciled each month. **HPN** had processes to assure timely and accurate loading of membership data. **HPN** tracked members using the system-issued number. This allowed linkage of data if a member lost and regained eligibility. **HPN** also had the ability to link members who switched product lines. For newborns, the State initially provided a file with the mother and an unborn baby identified for enrollment. Once the baby's birth was reported, the new enrollment file was updated to include the baby's new ID. There appeared to be no issues with linking the appropriate claims back to the newborn's record using the system ID. Several years ago the State encountered a technical issue with the enrollment files that has continued to cause some members to drop off the files each month. As a result, **HPN** had to manually correct approximately 200 member enrollments each month in 2016. Since **HPN** continued to work these adjustments manually each month, there was no impact to the HEDIS eligible populations.
- **HPN** was fully compliant with IS standard 3.0 for practitioner data. **HPN** had an increase of nearly 400 providers during 2016. It continued to use the Cactus software for provider credentialing and to determine provider types and specialties. All provider-related data elements required for the Medicaid HEDIS measures under the scope of the audit were captured and verified within the systems. The credentialing data were directly entered into Facets using the add-change-track (ACT) form, and then verified against the source data (Cactus). There were no issues identified and **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the *Board Certification* measure was not included in the scope of the audit, credentialing and recredentialing were not reviewed.
- **HPN** was fully compliant with IS standard 4.0. HSAG reviewed **HPN**'s IS 4 Roadmap pertaining to the policies and procedures for IS 4.0. The roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements. **HPN** sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. A review determined that provider chase logic was appropriate across the hybrid measures. **HPN** staff members procured and abstracted medical records using the Verscend Technologies, Inc. (Verscend's) hybrid medical record abstraction tools. HSAG participated in a live demonstration of the Verscend tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2017, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved the Verscend tools and instructions on January 6, 2017. **HPN** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of **HPN**'s abstraction tools to conduct medical record reviews accurately. **HPN** maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.
- **HPN** passed the MRRV in 2016 and did not make any significant changes to its staff, systems, or processes used for medical record review in 2017; therefore, a convenience sample was not required.

- **HPN** passed the MRRV process for the following measures and corresponding measure groups:
  - Group A: *Biometrics (BMI, BP) and Maternity—Prenatal and Postpartum Care—Postpartum Care*
  - Group B: *Anticipatory Guidance and Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (12–17 Years)*
  - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Control <8.0%*
  - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Testing*
  - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Poor Control >9.0%*
  - Group C: *Laboratory—Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - Group D: *Immunizations and Other Screenings—Immunizations for Adolescents—Combination 2*
  - Group F: *Exclusions—All medical record exclusions*
- **HPN** was fully compliant with IS standard 5.0 for supplemental data. **HPN** received laboratory data from Allscripts and Quest, and immunization registry data from the State. All of these databases were considered external, standard data. **HPN** had processes for data receipt, processing, and loading into the HEDIS vendor's software. **HPN** provided all the required supporting documentation for the standard databases and identified a nonstandard database, Touchworks, to use for reporting. This database contained one member for the *Comprehensive Diabetes Care—Eye Exam* measure. The one case was reviewed and passed the data validation process. There were no issues identified with any of the supplemental data and all standard and nonstandard databases were approved for HEDIS 2017 reporting.
- **HPN** was fully compliant with IS standard 7.0 for data integration. **HPN** used Verscend (formerly Verisk) to calculate its HEDIS rates. The data integration process has been consistent for many years. Data were loaded from Facets and the Corporate Reporting Database (CRD) directly into Kramer, the data warehouse repository. These data were then loaded into the Verscend software. Reports were generated during each load process to ensure accurate and complete data were captured. Additional reports were generated monthly to compare data in Kramer versus data in Verscend, as well as data in Kramer versus data in Facets and CRD. This high-level reporting system helped to ensure the appropriateness of the data and the accuracy of the data transfers.

  Query 3, primary source verification, was conducted on-site for 25 cases across several measures and no issues were identified. In addition, preliminary rates were reviewed prior to and during the on-site audit. *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rates appeared low; **HPN** acknowledged it was having difficulties improving the rates for this measure. Other rates that appeared low did not yet have medical record data incorporated. In general, Nevada Check Up rates were higher than the corresponding rates for Nevada Medicaid. A formal preliminary rate review was conducted after the on-site audit and rates appeared reasonable. The final rate review did not identify any issues and the patient level detail file matched the reported rates. Overall, there were no issues identified with the data integration process. Therefore, all of the rates were approved for reporting.

Medicaid Results

The Medicaid HEDIS 2015, 2016, and 2017 rates for **HPN** are presented in Table 5–4, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs as well as characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	91.42%	94.80%	95.17%	3.75
Ages 25 Months–6 Years	79.24%	84.29%	83.81%	4.57
Ages 7–11 Years	83.93%	87.36%	87.57%	3.64
Ages 12–19 Years	80.80%	85.21%	85.51%	4.71
Annual Dental Visit (ADV)				
Total	51.12%	55.03%	53.85%	2.73
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	37.47%	44.04%	44.77%	7.30
Childhood Immunization Status (CIS)				
Combination 2	70.80%	74.94%	73.72%	2.92
Combination 3	66.18%	70.32%	71.05%	4.87
Combination 4	66.18%	70.07%	71.05%	4.87
Combination 5	53.04%	55.72%	61.07%	8.03
Combination 6	39.42%	38.44%	34.79%	-4.63
Combination 7	53.04%	55.72%	61.07%	8.03

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Combination 8	39.42%	38.44%	34.79%	-4.63
Combination 9	32.36%	31.14%	30.41%	-1.95
Combination 10	32.36%	31.14%	30.41%	-1.95
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	79.81%	80.78%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	27.49%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	51.58%	53.77%	62.77%	11.19
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.83%	64.48%	65.21%	4.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	70.32%	71.78%	NC
Counseling for Nutrition—Total	—	57.91%	62.29%	NC
Counseling for Physical Activity—Total[1]	—	52.07%	59.61%	NC
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	77.62%	73.97%	72.75%	-4.87
Postpartum Care	58.88%	57.18%	59.12%	0.24
Frequency of Ongoing Prenatal Care (FPC)				
*<21 Percent of Expected Visits**	17.03%	14.60%	11.19%	-5.84
≥81 Percent of Expected Visits	51.34%	52.07%	60.83%	9.49
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)[1]				
Hemoglobin A1c (HbA1c) Testing	84.18%	85.64%	82.73%	-1.45
*HbA1c Poor Control (>9.0%)**	44.53%	45.74%	42.82%	-1.71
HbA1c Control (<8.0%)	43.80%	46.47%	48.42%	4.62
Eye Exam (Retinal) Performed	55.96%	56.93%	61.31%	5.35

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Medical Attention for Nephropathy	82.73%	92.21%	90.75%	8.02
Blood Pressure Control (<140/90 mm Hg)	70.32%	60.83%	50.36%	-19.96
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	46.96%	53.37%	NC
Medication Compliance 75%—Total	—	24.14%	32.81%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	48.49%	56.51%	79.16%	30.67
30-Day Follow-Up	66.89%	69.41%	84.20%	17.31
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	46.65%	43.68%	NC
Continuation and Maintenance Phase	—	58.02%	49.28%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]				
Total	—	1.80%	2.26%	NC
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
Any Service (Total)	4.66%	5.90%	6.80%	2.14
Inpatient (Total)	0.27%	0.77%	0.78%	0.51
Intensive Outpatient or Partial Hospitalization (Total)	0.16%	0.23%	0.30%	0.14
Outpatient, ED, or Telehealth (Total)	4.57%	5.67%	6.73%	2.16
Ambulatory Care (AMB)—Total				
Outpatient Visits—Total	275.76	292.44	298.12	22.36
*ED Visits—Total**	45.67	49.39	52.60	6.93

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

HPN's performance improved from HEDIS 2015 to HEDIS 2017 in several areas, including access to primary care and some immunizations for children, well-child visits for infants, well-care visits for adolescents and, most notably, timely follow-up care for members hospitalized for mental illness. **HPN**'s rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017, but rates for the measure assessing timely prenatal care indicated a performance decline year over year, suggesting opportunities for improvement.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, and 2017 rates for **HPN** are presented in Table 5–5, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	94.70%	99.48%	98.50%	3.80
Ages 25 Months–6 Years	87.20%	89.55%	89.61%	2.41
Ages 7–11 Years	93.83%	93.54%	92.98%	-0.85
Ages 12–19 Years	90.79%	90.78%	91.29%	0.50
Annual Dental Visit (ADV)				
Total	69.50%	70.11%	68.88%	-0.62
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	55.47%	52.83%	54.74%	-0.73
Childhood Immunization Status (CIS)				
Combination 2	83.46%	87.93%	84.38%	0.92
Combination 3	77.17%	84.48%	82.14%	4.97

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Combination 4	76.38%	83.91%	82.14%	5.76
Combination 5	66.14%	79.89%	71.88%	5.74
Combination 6	48.03%	52.30%	41.52%	-6.51
Combination 7	65.35%	79.31%	71.88%	6.53
Combination 8	47.24%	51.72%	41.52%	-5.72
Combination 9	42.52%	50.00%	37.50%	-5.02
Combination 10	41.73%	49.43%	37.50%	-4.23
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	87.35%	87.59%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	38.69%	NC
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	60.00%	68.00%	63.49%	3.49
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95%	70.13%	67.64%	-4.31
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	72.02%	73.24%	NC
Counseling for Nutrition—Total	—	60.34%	61.07%	NC
Counseling for Physical Activity—Total[1]	—	57.18%	58.39%	NC
Care for Chronic Conditions				
Medication Management for People with Asthma (MMA)				
Medication Compliance 50%—Total	—	47.62%	51.02%	NC
Medication Compliance 75%—Total	—	26.98%	27.89%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	NA	NA	NA	NC
30-Day Follow-Up	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	39.53%	48.89%	NC

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Continuation and Maintenance Phase	—	NA	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]				
Total	—	NA	NA	NC
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
Any Service (Total)	3.87%	4.71%	5.19%	1.32
Inpatient (Total)	0.19%	0.14%	0.22%	0.03
Intensive Outpatient or Partial Hospitalization (Total)	0.50%	0.55%	0.77%	0.27
Outpatient, ED, or Telehealth (Total)	3.83%	4.67%	5.18%	1.35
Ambulatory Care (AMB)—Total				
Outpatient Visits—Total	259.27	259.29	252.28	-6.99
*ED Visits—Total**	18.83	21.00	22.11	3.28

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

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Small Denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

HPN's rates demonstrated mixed performance in the area of immunizations for children from HEDIS 2015 to HEDIS 2017. Vaccination rates for combinations 4, 5, and 7 increased by greater than 5 percentage points and vaccination rates for combinations 6, 8, and 9 decreased by greater than 5 percentage points. These changes present opportunities for **HPN** to focus efforts on determining root causes linked to improvements and declines in performance.

Summary of HPN Strengths

The following Medicaid performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 5* and *7*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits* and *≥81 Percent of Expected Visits*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Medical Attention for Nephropathy*[5-2]
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Childhood Immunization Status—Combinations 4, 5,* and *7*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-3]

The following Nevada Check Up performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

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

[5-2] Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

[5-3] Ibid.

Plan Comparison

The HEDIS 2017 measure rates for **HPN**, **Amerigroup**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations relative to the Quality Compass national Medicaid percentiles for HEDIS 2016 are shown in Table 5–7 and Table 5–9. Measure results were compared to benchmarks and rated using the following star ratings:

Table 5–6—HEDIS Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

For the measures denoted with an asterisk (*) (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), lower rates indicate better performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs as well as characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only, and comparisons to benchmarks were not conducted.

Medicaid Results

Table 5–7 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.

Table 5–7—HEDIS 2017 Results for Medicaid

HEDIS Measure	AGP	HPN	Medicaid
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	93.83% ★★	95.17% ★★	94.55% ★★
Ages 25 Months–6 Years	82.25% ★	83.81% ★	83.08% ★
Ages 7–11 Years	86.59% ★	87.57% ★	87.16% ★

HEDIS Measure	AGP	HPN	Medicaid
Ages 12–19 Years	82.95% ★	85.51% ★	84.54% ★
Annual Dental Visit (ADV)			
Total	51.63% ★★	53.85% ★★★	52.91% ★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	47.69% ★★	44.77% ★★	45.88% ★★
Childhood Immunization Status (CIS)			
Combination 2	72.92% ★★	73.72% ★★	73.33% ★★
Combination 3	67.13% ★★	71.05% ★★	69.12% ★★
Combination 4	66.67% ★★	71.05% ★★★	68.90% ★★★
Combination 5	56.71% ★★	61.07% ★★★	58.93% ★★
Combination 6	36.11% ★★	34.79% ★★	35.44% ★★
Combination 7	56.25% ★★	61.07% ★★★	58.71% ★★★
Combination 8	36.11% ★★	34.79% ★★	35.44% ★★
Combination 9	32.18% ★★	30.41% ★★	31.28% ★★
Combination 10	32.18% ★★	30.41% ★★	31.28% ★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	79.40% ★★★	80.78% ★★★	80.25% ★★★
Combination 2 (Meningococcal, Tdap, HPV)	26.85% NC	27.49% NC	27.25% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	62.50% ★★★	62.77% ★★★	62.64% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.72% ★★	65.21% ★★	66.85% ★★

HEDIS Measure	AGP	HPN	Medicaid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	70.14% ★★★	71.78% ★★★	71.10% ★★★
Counseling for Nutrition—Total	62.73% ★★★	62.29% ★★	62.47% ★★
Counseling for Physical Activity—Total	56.48% ★★★	59.61% ★★★	58.31% ★★★
Maternity Care			
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	83.33% ★★★	72.75% ★	77.85% ★★
Postpartum Care	62.50% ★★★	59.12% ★★	60.75% ★★
Frequency of Ongoing Prenatal Care (FPC)			
*<21 Percent of Expected Visits**	5.56% ★★★	11.19% ★★	8.47% ★★
≥81 Percent of Expected Visits	62.50% ★★★	60.83% ★★★	61.63% ★★★
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)			
Hemoglobin A1c (HbA1c) Testing	81.02% ★	82.73% ★	82.10% ★
*HbA1c Poor Control (>9.0%)**	46.30% ★★	42.82% ★★★	44.10% ★★
HbA1c Control (<8.0%)	45.60% ★★	48.42% ★★★	47.38% ★★★
Eye Exam (Retinal) Performed	59.49% ★★★	61.31% ★★★	60.64% ★★★
Medical Attention for Nephropathy	90.28% ★★	90.75% ★★★	90.58% ★★★
Blood Pressure Control (<140/90 mm Hg)	61.11% ★★★	50.36% ★	54.33% ★★
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	56.19% ★★★	53.37% ★★	54.52% ★★
Medication Compliance 75%—Total	32.16% ★★★	32.81% ★★★	32.54% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	79.81% ★★★★★	79.16% ★★★★★	79.52% ★★★★★
30-Day Follow-Up	84.98% ★★★★★	84.20% ★★★★★	84.63% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	43.51% ★★★	43.68% ★★★	43.60% ★★★
Continuation and Maintenance Phase	64.91% ★★★★	49.28% ★★	56.35% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]			
Total	3.74% ★	2.26% ★★	2.92% ★★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
Any Service (Total)	8.63% NC	6.80% NC	7.57% NC
Inpatient (Total)	1.16% NC	0.78% NC	0.94% NC
Intensive Outpatient or Partial Hospitalization (Total)	0.24% NC	0.30% NC	0.28% NC
Outpatient, ED, or Telehealth (Total)	8.50% NC	6.73% NC	7.47% NC
Ambulatory Care (AMB)—Total			
Outpatient Visits—Total	287.09 NC	298.12 NC	293.47 NC
*ED Visits—Total**	54.02 NC	52.60 NC	53.20 NC

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles because these values were derived using the HEDIS 2016 technical specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

Amerigroup's and **HPN**'s rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* ranked at or above the national Medicaid 90th percentile for HEDIS 2017, indicating timely follow-up care for members hospitalized for mental illness.

However, both MCOs' rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years*, as well as *Comprehensive Diabetes Care—HbA1c Testing* fell below the national Medicaid 25th percentile, indicating areas for improvement related to access to care for children and adolescents, and appropriate HbA1c testing for members with diabetes.

HPN's rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* fell below the national Medicaid 25th percentile, while **Amerigroup**'s rates were more than 10 percentage points higher than **HPN**'s rates and ranked at or above the national 50th percentile, which suggests that timely prenatal care for pregnant women and blood pressure control for members with diabetes are opportunities for improvement for **HPN**. Additionally, **HPN**'s rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* fell below the national Medicaid 50th percentile, while **Amerigroup**'s rate for this measure indicator was almost 16 percentage points above **HPN**'s rate and ranked at or above the national 75th percentile. **HPN**'s rate did improve 9.36 percentage points over the previous year; however, there is still opportunity to improve the rate for follow-up care for children on ADHD medication further.

Data Completeness

Table 5–8 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2017 rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

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

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	47.69%	85.92%	44.77%	98.37%^
Childhood Immunization Status (CIS)				
Combination 2	72.92%	97.78%^	73.72%	84.49%
Combination 3	67.13%	96.90%^	71.05%	82.53%
Combination 4	66.67%	96.88%^	71.05%	82.53%

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Combination 5	56.71%	96.73%^	61.07%	82.07%
Combination 6	36.11%	96.15%^	34.79%	81.12%
Combination 7	56.25%	96.71%^	61.07%	82.07%
Combination 8	36.11%	96.15%^	34.79%	81.12%
Combination 9	32.18%	96.40%^	30.41%	79.20%
Combination 10	32.18%	96.40%^	30.41%	79.20%
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	79.40%	97.08%^	80.78%	93.98%^
Combination 2 (Meningococcal, Tdap, HPV)	26.85%	93.10%^	27.49%	89.38%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	62.50%	79.26%	62.77%	89.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.72%	93.66%^	65.21%	97.39%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	70.14%	**33.66%^^**	71.78%	**34.92%^^**
Counseling for Nutrition—Total	62.73%	**29.15%^^**	62.29%	**32.42%^^**
Counseling for Physical Activity—Total	56.48%	**11.48%^^**	59.61%	**15.51%^^**
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	83.33%	64.44%	72.75%	71.91%
Postpartum Care	62.50%	60.00%	59.12%	63.79%
Frequency of Ongoing Prenatal Care (FPC)				
<21 Percent of Expected Visits	5.56%	83.33%	11.19%	97.83%^
≥81 Percent of Expected Visits	62.50%	**22.22%^^**	60.83%	**25.60%^^**
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	81.02%	97.14%^	82.73%	99.12%^

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
HbA1c Poor Control (>9.0%)	46.30%	71.50%	42.82%	98.86%^
HbA1c Control (<8.0%)	45.60%	58.88%	48.42%	96.48%^
Eye Exam (Retinal) Performed	59.49%	89.88%	61.31%	87.70%
Medical Attention for Nephropathy	90.28%	99.23%^	90.75%	99.46%^
Blood Pressure Control (<140/90 mm Hg)	61.11%	**0.00%^^**	50.36%	**0.00%^^**

Green Shading^ indicates that more than 90 percent of the final rate was derived from administrative data.

Red Shading^^ indicates that 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 27 rates for the Medicaid population using the hybrid methodology. Fourteen rates reported by **Amerigroup** (i.e., more than half of **Amerigroup**'s hybrid rates) were derived using more than 90 percent administrative data, indicating high levels of encounter data completeness. Eight rates reported by **HPN** (less than one-third of **HPN**'s rates) were derived using more than 90 percent administrative data. For both MCOs, five rates were derived using 50 percent or less administrative data, including rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators, *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*. However, for these measures the numerator-positive hits are often detected primarily through medical record review, not administrative data.

Nevada Check Up Results

Table 5–9 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.[5-4]

Table 5–9—HEDIS 2017 Results for Nevada Check Up

HEDIS Measure	AGP	HPN	NV Check Up
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	98.18% ★★★★★	98.50% ★★★★★	98.36% ★★★★★
Ages 25 Months–6 Years	89.45% ★★★	89.61% ★★★	89.54% ★★★
Ages 7–11 Years	91.83% ★★★	92.98% ★★★	92.55% ★★★
Ages 12–19 Years	91.08% ★★★	91.29% ★★★	91.22% ★★★
Annual Dental Visit (ADV)			
Total	67.81% ★★★★★	68.88% ★★★★★	68.48% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	60.88% ★★★★	54.74% ★★★	56.79% ★★★
Childhood Immunization Status (CIS)			
Combination 2	91.16% ★★★★★	84.38% ★★★★★	87.39% ★★★★★
Combination 3	82.87% ★★★★★	82.14% ★★★★★	82.47% ★★★★★
Combination 4	81.22% ★★★★★	82.14% ★★★★★	81.73% ★★★★★
Combination 5	72.93% ★★★★★	71.88% ★★★★★	72.34% ★★★★★
Combination 6	47.51% ★★★★	41.52% ★★★	44.18% ★★★

[5-4] Because national benchmarks for HEDIS measures are not available for the Children's Health Insurance Program (CHIP) population, comparisons of Nevada's Check Up population rates to the national Medicaid percentiles should be interpreted with caution.

HEDIS Measure	AGP	HPN	NV Check Up
Combination 7	72.38% ★★★★★	71.88% ★★★★★	72.10% ★★★★★
Combination 8	47.51% ★★★★	41.52% ★★★	44.18% ★★★
Combination 9	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Combination 10	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	83.61% ★★★★	87.59% ★★★★★	86.28% ★★★★
Combination 2 (Meningococcal, Tdap, HPV)	38.46% NC	38.69% NC	38.61% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	78.92% ★★★★★	63.49% ★★★	70.70% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16% ★★★	67.64% ★★	71.34% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	71.30% ★★★	73.24% ★★★	72.52% ★★★
Counseling for Nutrition—Total	65.28% ★★★	61.07% ★★	62.61% ★★
Counseling for Physical Activity—Total	59.72% ★★★	58.39% ★★★	58.88% ★★★
Care for Chronic Conditions			
Medication Management for People with Asthma (MMA)			
Medication Compliance 50%—Total[1]	58.43% ★★★	51.02% ★★	53.81% ★★
Medication Compliance 75%—Total	24.72% ★	27.89% ★★	26.69% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	82.50% ★★★★★	NA	80.00% ★★★★★
30-Day Follow-Up	97.50% ★★★★★	NA	92.31% ★★★★★

HEDIS Measure	AGP	HPN	NV Check Up
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	41.67% ★★	48.89% ★★★	45.68% ★★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2,*]			
Total	NA	NA	5.71% ★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
Any Service (Total)	5.68% NC	5.19% NC	5.38% NC
Inpatient (Total)	0.42% NC	0.22% NC	0.29% NC
Intensive Outpatient or Partial Hospitalization (Total)	0.16% NC	0.77% NC	0.53% NC
Outpatient, ED, or Telehealth (Total)	5.64% NC	5.18% NC	5.36% NC
Ambulatory Care (AMB)—Total			
Outpatient Visits—Total	258.30 NC	252.28 NC	254.60 NC
*ED Visits—Total**	26.30 NC	22.11 NC	23.73 NC

* A lower rate indicates better performance for this measure.

[1] Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

[2] Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates to national benchmarks that were derived using NCQA's HEDIS 2016 specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

NA (i.e., Small Denominator) indicates the health plan(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup's and **HPN**'s HEDIS 2017 rates for the Nevada Check Up population indicate positive performance related to access to primary care, dental care, and immunizations for children. Specifically, the MCOs' rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months*, *Annual Dental Visit—Total*, and *Childhood Immunization Status—Combinations 2–5*, ranked at or above the national Medicaid 90th percentile.

Amerigroup's rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* ranked at or above the national Medicaid 90th percentile, demonstrating timely follow-up care for members hospitalized for mental illness.

Conversely, **HPN**'s rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was below the national Medicaid 75th percentile, but **Amerigroup**'s rate for this measure was above the national Medicaid 90th percentile and more than 15 percentage points above **HPN**'s rate, indicating there were opportunities for improvement for access to well-child visits for infants for **HPN**.

As mentioned previously, comparisons between Nevada's Check Up population rates to national Medicaid benchmarks should be interpreted with caution.

Data Completeness

Table 5–10 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2017 rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5–10—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	60.88%	87.45%	54.74%	98.67%^
Childhood Immunization Status (CIS)				
Combination 2	91.16%	97.58%^	84.38%	88.36%
Combination 3	82.87%	96.67%^	82.14%	86.96%
Combination 4	81.22%	96.60%^	82.14%	86.96%
Combination 5	72.93%	97.73%^	71.88%	86.34%
Combination 6	47.51%	97.67%^	41.52%	80.65%
Combination 7	72.38%	97.71%^	71.88%	86.34%
Combination 8	47.51%	97.67%^	41.52%	80.65%
Combination 9	44.75%	98.77%^	37.50%	79.76%
Combination 10	44.75%	98.77%^	37.50%	79.76%

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	83.61%	97.60%^	87.59%	91.67%^
Combination 2 (Meningococcal, Tdap, HPV)	38.46%	95.65%^	38.69%	83.02%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	78.92%	80.92%	63.49%	85.00%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16%	93.62%^	67.64%	96.76%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	71.30%	**28.90%^^**	73.24%	**33.22%^^**
Counseling for Nutrition—Total	65.28%	**26.60%^^**	61.07%	**34.66%^^**
Counseling for Physical Activity—Total	59.72%	**15.89%^^**	58.39%	**19.17%^^**

Green Shading^ indicates that more than 90 percent of the final rate was derived from administrative data.

Red Shading^^ indicates that 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 17 rates for the Nevada Check Up population using the hybrid methodology. Twelve rates reported by **Amerigroup** (i.e., more than half of **Amerigroup**'s hybrid rates) were derived using more than 90 percent administrative data, as were three rates reported by **HPN**. Rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators for both MCOs were derived using 50 percent or less administrative data. However, for these measures, numerator-positive hits are often detected primarily through medical record review, not administrative data.

Amerigroup Conclusions and Recommendations

Conclusions

The NCQA HEDIS compliance audits demonstrated that **Amerigroup** had adequate policies and procedures to collect, prepare, process, and report HEDIS data and the MCO was in full compliance with each of the six NCQA-specified IS standards. **Amerigroup** continued to use Facets to process its claims. Data entry processes were efficient, with the assurance of timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. **Amerigroup** applied several validation checks to ensure accurate information processing.

For the Medicaid population performance measure evaluation, **Amerigroup**'s HEDIS 2017 rates as compared to the national Medicaid percentiles indicated strong performance related to timely follow-up care for members hospitalized for mental illness. **Amerigroup**'s rates for this measure demonstrated notable improvements from HEDIS 2015 to HEDIS 2017. **Amerigroup**'s performance improved from HEDIS 2015 to HEDIS 2017 with regard to well-child visits for infants and well-care visits for adolescents. Additionally, **Amerigroup**'s rates for immunizations for children, dental care for children, and prenatal/postpartum care for pregnant women demonstrated improvements from HEDIS 2015 to HEDIS 2017. Although there was no rate for weight assessment and counseling for nutrition and physical activity for children in HEDIS 2015, the comparison from HEDIS 2016 to HEDIS 2017 showed that each of the three indicators improved by 6 percentage points or more and all indicators were above the 50th national Medicaid percentile. **Amerigroup** also demonstrated strong improvement from HEDIS 2016 to HEDIS 2017 for medication management for people with asthma and follow-up care for children prescribed ADHD medication.

Amerigroup's HEDIS 2017 rates as compared to the national Medicaid percentiles indicated areas for improvement related to access to care for children/adolescents and appropriate HbA1c testing for members with diabetes.

For the Nevada Check Up population performance measure evaluation, **Amerigroup**'s HEDIS 2017 rates indicated positive performance related to access to primary care and dental care for children as compared to the national Medicaid percentiles. **Amerigroup**'s rates also demonstrated timely follow-up care for members hospitalized for mental illness for the 30-day follow up visit. **Amerigroup**'s performance improved from HEDIS 2015 to HEDIS 2017 in the areas of immunizations for children and well-child visits for infants.

Recommendations

Amerigroup's HEDIS 2017 Medicaid population rates indicated areas for improvement related to access to care for children/adolescents. While all four children/adolescent access to care indicators have shown slight improvement from HEDIS 2015 to HEDIS 2017, the rates demonstrate opportunities for improvement when compared to the national Medicaid percentiles. In conducting a causal barrier analysis to determine causes that impact CAHPS rates (see Section 9 of this report for more information), **Amerigroup** staff members reported that the expansion of Medicaid eligibility in 2014 may have strained the provider network and, as a result, negatively impacted the availability of appointments. For HEDIS 2017, the denominators in each of the children's access to primary care indicators increased, which was expected with Medicaid expansion. In 2016, **Amerigroup** hired additional provider relations consultants to review the network and contract with additional providers to fill network gaps. It is possible that the timing of these efforts may not have been early enough to positively impact the availability of appointments to such a degree that it would improve children's and adolescents access to care. Since *Children and Adolescents' Access to Primary Care Practitioners* is an access-related measure, HSAG recommends that **Amerigroup** continue to evaluate the adequacy of its provider network for children's services, including capacity and geographic locations, to determine if a sufficient number of providers have been added to improve capacity and accessibility. Further, **Amerigroup** should evaluate the provider appointment availability for children and adolescents as part

of its secret shopper survey activities, which is one of the new contract requirements for the MCOs operating in the Nevada managed care program.

Amerigroup's HEDIS 2017 Medicaid population rates also indicated areas for improvement related to HbA1c testing for diabetic members. In its 2016 Annual Quality Evaluation, **Amerigroup** reported an increase in enrollment in the disease management program for diabetics. Of the 3,673 members enrolled in disease management for diabetes, 96.8 percent received "passive management," which according to the **Amerigroup** quality evaluation meant that members were "considered lower risk and received non-interactive interventions, including condition-specific educational mailings." According to **Amerigroup**'s quality evaluation, members enrolled in active management had "complex, comorbid conditions and worked collaboratively with a nurse case manager by phone to establish holistic goals, develop a plan of care, and track progress toward meeting goals." HSAG recommends that **Amerigroup** evaluate the effectiveness of active disease management compared to passive disease management to determine if active disease management with a care manager, or components of it, are more effective in meeting numerator compliance for the *Comprehensive Diabetes Care* indicators. By evaluating the effectiveness of its interventions, **Amerigroup** will be able to discern the most effective interventions and spread those across the population.

HPN Conclusions and Recommendations

Conclusions

The NCQA HEDIS compliance audits demonstrated that **HPN** had adequate policies and procedures to collect, prepare, process, and report HEDIS data and was in full compliance with each of the six NCQA-specified IS standards. **HPN** continued to use Facets to process its claims. Data entry processes were efficient, with the assurance of timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. **HPN** applied several validation checks to ensure accurate information processing.

For the Medicaid population performance measure evaluation, **HPN**'s HEDIS 2017 rates as compared to the national Medicaid percentiles indicated positive performance related to timely follow-up care for members hospitalized for mental illness. **HPN**'s rates for this measure also demonstrated notable improvements from HEDIS 2015 to HEDIS 2017. **HPN**'s performance improved from HEDIS 2015 to HEDIS 2017 with regard to well-child visits for infants and well-care visits for adolescents. Some of the measures were not required for HEDIS 2015; however, **HPN** did show improvement from HEDIS 2016 to HEDIS 2017 for the following measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, and *Medication Management for People With Asthma*.

HPN's Medicaid rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017, but rates for the measure assessing timely prenatal care showed a decline in performance year over year, indicating opportunities for improvement. Comparisons of **HPN**'s timely prenatal care rates as compared to the national Medicaid percentiles also suggested opportunities for improvement in this area. **HPN**'s HEDIS 2017 rates compared to the national Medicaid percentiles indicated areas for improvement related to access to care for children/adolescents and appropriate HbA1c testing for

members with diabetes. Further, **HPN**'s rates as compared to the national Medicaid percentiles presented opportunities for improvement for blood pressure control for members with diabetes and follow-up care for children on ADHD medication.

For the Nevada Check Up population performance measure evaluation, **HPN**'s HEDIS 2017 rates indicated positive performance related to access to primary care and dental care for children as compared to the national Medicaid percentiles. **HPN**'s rates demonstrated mixed performance in the area of immunizations for children from HEDIS 2015 to HEDIS 2017, with vaccination rates for combinations 4, 5, and 7 increasing by greater than 5 percentage points and vaccination rates for combinations 6, 8, and 9 decreasing by greater than 5 percentage points. These changes present opportunities for **HPN** to focus efforts on determining root causes linked to improvements and declines in performance. Additionally, **HPN**'s rates present opportunities for improvement for access to well-child visits for infants as compared to the national Medicaid percentiles.

Recommendations

HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement for access to care for children/adolescents when compared to national Medicaid percentiles, even though all of the indicators have shown improvement based on performance from HEDIS 2015 to HEDIS 2017. The **HPN** 2016 Quality Improvement Program Evaluation contained a subgroup analysis performed at **HPN** for the access to care for children/adolescent indicators, which included an analysis by race/ethnicity for all four indicators. The annual evaluation did not show, however, an analysis of numerator compliance by geographic location. Since access to primary care for children and adolescents is an access-related measure, HSAG recommends that **HPN** evaluate the numerator compliance by geographic location to determine if disparities exist. Further, **HPN** should continue to evaluate the adequacy of its provider network by geographic location to determine if the network has a sufficient number of available pediatric providers to serve the population. When completing its contractually required secret shopper survey to determine appointment availability, **HPN** should ensure that pediatricians are included in the sample to determine if network pediatricians are accepting new patients and if appointments are available.

HPN's rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017. This suggests that once pregnant women are identified in **HPN**'s population, the MCO's strategies to increase the number of prenatal care visits for women have been successful. The decline in performance for **HPN**'s rate for timeliness of prenatal care, however, suggests that pregnant women either haven't been identified early enough in the pregnancy or enrollment in the MCO, or once identified, pregnant women are not receiving prenatal services as quickly as they should. This could indicate an access to care issue. HSAG recommends that **HPN** evaluate the availability of prenatal care appointments within its provider network to determine if providers are accepting new patients and if earlier appointments may be established for members. The secret shopper survey the MCOs are required to complete as part of the MCO contract 3260 will be helpful in determining appointment availability for pregnant members.

HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement related to HbA1c testing and blood pressure control for members with diabetes when compared to national Medicaid percentiles. The **HPN** 2016 Quality Improvement Program Evaluation showed an evaluation and analysis of comprehensive diabetes care indicators (e.g., race and ethnicity analysis); however, HbA1c testing was not included as one of the indicators. Further, the **HPN** 2017 Quality Improvement Work Plan did not include diabetes care goals for the Medicaid population. HSAG recommends that **HPN** conduct detailed analyses to determine the factors that are impacting performance in these areas. Further, HSAG recommends that **HPN** establish performance goals for HbA1c testing and blood pressure control for Medicaid members with diabetes and evaluate interventions to determine which have the greatest impact on the Medicaid population. The prioritization to study and improve HbA1c testing for Medicaid members with diabetes has the potential to earn **HPN** a performance award since it is one of the pay-for-performance indicators identified by the DHCFP.

HPN's rates presented opportunities for improvement for follow-up care for children on ADHD medication, where both indicators demonstrated a decline in performance from HEDIS 2016 to HEDIS 2017 and the continuation and maintenance phase indicator fell below the 50th national Medicaid percentile. HSAG noted that the **HPN** 2016 Quality Improvement Program Evaluation did not include an analysis of the measure *Follow-Up Care for Children Prescribed ADHD Medication*, as it did for other Medicaid performance measures. Further, the **HPN** 2017 Quality Improvement Work Plan did not include any goals for the performance measure. HSAG recommends that to identify interventions that may improve rates, **HPN** monitor performance related to care for children on ADHD medication in a manner similar to what is performed for other Medicaid performance measures.

For the Nevada Check Up population performance measure evaluation, **HPN**'s rates demonstrated mixed performance for immunizations for children, with select vaccination rates improving from the previous year and select vaccinations rates declining. Those that declined were combinations 6, 8, 9, and 10. This same trend existed for both Medicaid and Nevada Check Up populations. These combination vaccines are the only ones that include the influenza antigen, which may have been the missing antigen that caused the decline in rates. For example, the only difference between combinations 3 and 6 is the inclusion of the influenza antigen in combination 6. All other antigens are the same between the two combinations and the combination 3 vaccine demonstrated a 4.97 percentage point increase from HEDIS 2015 to HEDIS 2017 for the Nevada Check Up population. HSAG recommends that **HPN** conduct a root cause analysis to determine the factors that may be impacting the immunization rates that contain the influenza antigen, such as failure of the provider offices to administer the recommended vaccines; failure to report the vaccines to WebIZ, which is Nevada's immunization registry; or failure of a provider, who is not the child's primary care provider, to report to WebIZ in the event the child received the vaccine at a flu clinic or pharmacy, for example. **HPN** might benefit from hosting a focused discussion with parents of children who were not numerator-compliant to determine if there are other factors that might impede immunizations that contain the influenza antigen. Since the Medicaid pay-for-performance incentive for MCOs includes the measure *Childhood Immunization Status—Combination 10*, **HPN** will be rewarded for improving this measure beyond the minimum performance standard for the Medicaid population.

6. Validation of Performance Improvement Projects—SFY 2016–2017

As described in 42 CFR §438.240 (b)(1), the DHCFP requires MCOs to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction.

Over time, HSAG and some of its contracted states identified that while MCOs have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few of them actually achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine what interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012.[6-1] HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that—with the pace of quality improvement science development and the prolific use of plan, do, study, act (PDSA) cycles in modern improvement projects within healthcare settings—a new approach was needed. After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS approved the DHCFP to implement this new PIP approach in the State of Nevada.

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that an MCO serves. This structure facilitates the documentation and evaluation of improvements in care or services. MCOs conduct PIPs to assess and improve the quality of clinical and nonclinical health care and services received by recipients.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.240 (b)(1) and 42 CFR §438.240 (d)(1)(1-4), including:

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2013.

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of interventions.
- Planning and initiation of activities to increase or sustain improvement.

For the rapid-cycle PIP approach, HSAG developed five modules with an accompanying companion guide. Throughout SFY 2016–2017, HSAG continued to provide guidance, training, and oversight for the MCO's PIPs. HSAG has been involved from the onset of the PIPs to determine methodological soundness and to ensure that MCOs had the knowledge and guidance needed to be successful, not only in documenting its approach but also in applying the rapid-cycle quality improvement methods that are central to achieving improved outcomes. For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* PIP, HSAG received DHCFP instructions for the MCOs to include all three components in each MCO's SMART Aim statement. HSAG's validation requirements, which were approved by the DHCFP, stipulated that the MCOs must achieve the goal set for each component of the SMART Aim in order for the PIP to receive a rating of *Confidence* or *High Confidence*. See Appendix A, Technical Methods of Data Collection and Analysis, for more information on PIP validation scoring.

Plan-Specific Results—Amerigroup

In SFY 2016–2017, **Amerigroup** continued with the DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions* and progressed to completing Modules 4 and 5 (Plan-Do-Study-Act [PDSA]: Intervention Testing and PIP Conclusions). The topics, selected by the DHCFP, addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, **Amerigroup** defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement set the framework for the PIP and identified the goal against which the PIP was evaluated for the annual validation.

Table 6–1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	By March 31, 2017, the MCO aims to increase the compliance rate for body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity among children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner, from 78.24 percent to 88.24 percent, from 58.33 percent to 68.33 percent, and from 57.41 to 67.41 percent, respectively.

PIP Title	SMART Aim Statement
Behavioral Health Hospital Readmissions	By March 31, 2017, the MCO aims to reduce the number of inpatient behavioral health readmissions in Clark County by 10 percentage points from 29.07 percent to 19.07 percent.

HSAG organized and analyzed the PIP information and data submitted by **Amerigroup** to draw conclusions about the MCOs' quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) PIP

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

Amerigroup tested two interventions and submitted two Module 4 documents for validation.

The first intervention involved conducting training sessions that included the electronic health record documentation measure components using the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) Quick Reference Guide (QRG). The MCO selected the provider and office staff at the Nevada Health Center (NVHC) Martin Luther King (MLK) location. The purpose of this test was to determine if providing education and training to the staff on correct coding and documentation standards for the three components of the *WCC* measure would improve compliance. The training sessions occurred from September 14, 2016 through October 6, 2016. Prior to the training, **Amerigroup** administered a pre-test to obtain participants' current knowledge. At the conclusion of each training session, each participant was given a post-test comprising the same questions as the pre-test to determine the knowledge gained from the training. After analysis of the pre- and post-test data, **Amerigroup** determined statistically significant improvement in the post-test scores. Because of this improvement, the MCO determined that it would continue testing on a larger scale at other NVHC locations.

The second intervention involved targeted QRG education and reeducation for the NVHC MLK location providers. Medical record reviews were conducted by the MCO's quality management nurse during August through November. Data gathered during August and September (before training occurred) were used for comparison to assess post-training compliance rates for October and November. The MCO compared pre-training medical record review data to post-medical record review data to determine the success in increasing the *WCC* documentation compliance rates for the NVHC MLK providers. The intervention was abandoned because the post-training data showed that the QRG training was not successful in increasing the documentation compliance rates.

Upon initial validation of the first Module 4 submitted for the *WCC* PIP, opportunities for improvement were identified within the MCO's summary of findings. **Amerigroup** sought technical assistance from HSAG prior to resubmitting the module. The MCO made the necessary corrections and met all of the validation criteria on the final validation. For the second Module 4 submitted, HSAG identified opportunities for improvement with the MCO's summary of findings and intervention testing results reported. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections, submitted the module for final validation, and achieved all of the validation criteria.

To sustain improvement that was achieved during the PIP process, **Amerigroup**'s documentation described the MCO's intent to provide training for medical assistants and providers during scheduled training sessions and on-site visits to include proper documentation. The public relations (PR) director would monitor activities of those who conduct training and site visits, as well as recruitment of facilities. Quality managers and the HEDIS support team were required to provide support when needed. The data collected was used to secure buy-in from facilities in meetings prior to implementation. Ongoing data sharing was implemented, and data was shared with providers. The PR staff, PR director, and HEDIS team planned to communicate ongoing *WCC* results to providers and provide technical support.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–2—SMART Aim Measure Results for the Weight Assessment PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and had a BMI percentile completed during an office visit.	78.2%	88.2%	88.0%	*Low Confidence*
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and received counseling for nutrition during an office visit.	58.3%	68.3%	77.0%	
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and received counseling for physical activity during an office visit.	57.4%	67.4%	77.0%	

Amerigroup established a goal of increasing the BMI percentile completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 78.2 percent to 88.2 percent. The SMART Aim measure rate did not achieve the goal of 88.2 percent, with the highest rate achieved being 88.0 percent. From March 2016 to March 2017, the MCO was able to achieve improvement above the baseline rate for two months. However, the remaining 11 months' performance did not improve, and rates were below the baseline rate of 78.2 percent.

Amerigroup set a goal of increasing the counseling for nutrition completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 58.3 percent to 68.3 percent. The SMART Aim measure rate exceeded the goal of 68.3 percent, with the highest rate achieved being 77.0 percent. The SMART Aim measure goal was exceeded for two of the 13 months from March 2016 to March 2017. In addition, **Amerigroup** was able to achieve improvement above the baseline rate for five consecutive months. The remaining eight months' performance did not improve, and rates were below the baseline rate of 58.3 percent.

Amerigroup set a goal of increasing the counseling for physical activity completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 57.4 percent to 67.4 percent. The SMART Aim measure rate exceeded the goal of 68.3 percent, with the highest rate achieved being 77.0 percent. The SMART Aim measure goal was exceeded for two of the 13 months from March 2016 to March 2017. In addition, **Amerigroup** was able to achieve improvement above the baseline rate for five consecutive months. The remaining eight months' performance did not improve, and rates were below the baseline rate of 57.4 percent.

Upon initial validation of Module 5, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving guidance from HSAG, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of the Module 5 validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was only achieved for two of the three measure components.

Behavioral Health Hospital Readmissions PIP

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

Amerigroup tested two interventions and submitted two Module 4 documents for validation.

The first intervention involved provider training and education of the Patient360 system. Patient360 is a longitudinal patient record that allows providers to view content such as claims, authorizations, labs, pharmacy and medication information, and clinical history. This system is a new initiative; therefore, the providers in the facility did not know how to use the system. To implement this intervention, the MCO identified Spring Mountain Medical Center as its location for testing and selected 12 participants. Training sessions occurred from September 23 through September 30, 2016. Immediately following the training course, the MCO administered a survey to measure the provider's knowledge of the Patient360 system. After analyzing the survey data, **Amerigroup** determined that all participants who received the

training were able to log into the system correctly, and all but one could access the member's clinical information and complete the member's treatment and discharge plan. Based on the intervention results, **Amerigroup** chose to adopt this intervention and will spread it to all providers. New providers will be trained to use Patient360 during the monthly new provider call.

The second intervention related to continued use of the Patient360 system at Spring Mountain. After the Patient360 training was completed, the next phase of the intervention involved generating reports to examine user logins and behavior, and provide targeted provider retraining, as needed. **Amerigroup** collected weekly user reports for 13 weeks and analyzed the data. **Amerigroup** adopted the intervention because the results from the intervention testing showed continued use of Patient360. In addition, readmission rates for members for whom a search was performed using Patient360 were 11.2 percent lower than readmission rates for members for whom a search was not performed using Patient360.

Upon initial validation of the first Module 4 submitted for the *Behavioral Health Hospital Readmissions* PIP, **Amerigroup** achieved all of the validation criteria, and a resubmission was not required. For the second Module 4 submitted, HSAG identified opportunities for improvement with the MCO's summary of findings and intervention testing results displayed on the run chart. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections, submitted the module for final validation, and achieved all of the validation criteria.

To sustain improvement that was achieved during the PIP process, **Amerigroup** will continue to work with Spring Mountain and offer regular Patient360 training for new associates, as well as refresher training for existing staff. Both interventions have been integrated into regular operating procedures. **Amerigroup** plans to continue tracking readmission rates to monitor for sustained improvement. The Utilization Management team has been trained to identify patterns in the rate that may signify the need for further improvement activities.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–3—SMART Aim Measure Results for the Behavioral Health PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The percentage of inpatient behavioral health readmissions in Clark County.	29.1%	19.1%	25.0%	*Low Confidence*

* The Lowest Rate Achieved is reported for the *Behavioral Health Hospital Readmissions* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

Amerigroup established a goal of reducing the inpatient behavioral health readmission rate for members in Clark County by 10 percentage points, from 29.1 percent to 19.1 percent. The SMART Aim measure rate did not achieve the goal of 19.1 percent, with the lowest rate achieved being 25.0 percent. From March 2016 to March 2017, the MCO was able to achieve improvement below the baseline rate

for four months. However, the remaining nine months' performance did not improve, and rates were above the baseline rate of 29.1 percent.

Upon initial validation of Module 5, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving guidance from HSAG, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of the Module 5 validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was not achieved.

Plan-Specific Results—HPN

In SFY 2017, **HPN** continued with the DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions* and progressed to completing Modules 4 and 5 (Intervention Testing and PIP Conclusions): The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, **HPN** defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement set the framework for the PIP and identified the goal against which the PIP was evaluated for the annual validation.

Table 6–4—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	By March 31, 2017, HPN aims to increase the WCC compliance rates for children 3–17 years of age assigned to Dr. Veeramachaneni to the following: body mass index (BMI) percentile documentation from 2.13 percent to 10 percent; counseling for nutrition from 4.79 percent to 12 percent; and counseling for physical activity from 2.66 percent to 10 percent.
Behavioral Health Hospital Readmissions	By March 31, 2017, decrease the rate of the identified top 50 utilizers of inpatient substance abuse and/or mental health admissions from 13.8 percent of the total membership's inpatient substance abuse and/or mental health admissions to 12 percent.

HSAG reviewed the data and information submitted by **HPN** to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim

measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) PIP

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

HPN tested two interventions and submitted two Module 4s for validation.

The first intervention involved the creation of a standardized operating procedure (SOP) for Dr. Veeramachaneni's office. This provider was selected due to a low rate for *WCC* documentation compliance. **HPN** trained the physician and office staff on the new SOP, which focused on the required documentation for the *WCC* measure in the medical record. Testing took place between July 15 and September 15, 2016. The initial effectiveness of this intervention was demonstrated by the increase in the number of medical records that contained documentation of all three required components for the *WCC* measure. **HPN** determined that it would adopt the intervention.

The second intervention involved the next step of the SOP, billing for the three required *WCC* components (BMI, counseling for nutrition, and counseling for physical activity). **HPN** trained the physician and office staff on accurately billing for each of the required *WCC* components. Testing took place between November 1, 2016, and February 24, 2017. A claims review was conducted for those members with an outpatient visit with Dr. Veeramachaneni during November, December, and January to ensure BMI percentile, nutrition counseling, and physical activity counseling were appropriately included in the outpatient visit submitted claim. During intervention testing, it was determined that the HEDIS codes were not universal and could only be used if specific services were rendered. This finding was problematic because the MCO would never be fully compliant. To determine the extent of the problem, **HPN** asked the provider to continue to include the appropriate codes in the outpatient claim. Although the number of claims with BMI increased, the number of claims for nutrition counseling never exceeded 23 percent, and counseling for physical activity remained at zero percent. Despite these challenges, the SMART Aim remained at 100 percent due to the medical record review. Although the intervention was not the primary reason for the SMART Aim to remain at 100 percent, it would serve as a good secondary intervention if the documentation was not available and if HEDIS increased the number of acceptable codes for the measure. Due to the challenges encountered, **HPN** abandoned the intervention and will research other possible interventions to test in the future.

Upon initial validation for both Module 4's submitted for the **HPN** met all of the validation criteria and a resubmission was not required. However, HSAG provided several general comments in the validation tool to assist and strengthen the MCO's testing of future interventions.

To sustain improvement that was achieved during the PIP process, Dr. Veeramachaneni's practice is committed to continuing the improvement beyond the SMART Aim goal end date, as well as expanding the intervention to include other providers in the practice. The practice will conduct internal medical record reviews to ensure an overall increase in documentation compliance.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–5—SMART Aim Measure Results for the Weight Assessment PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and had a BMI percentile completed during an office visit.	2.1%	10.0%	100%	*Confidence*
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and received counseling for nutrition during an office visit.	4.8%	12.0%	100%	
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and received counseling for physical activity during an office visit.	2.7%	10.0%	100%	

HPN established a goal of increasing the BMI percentile completion rate for Dr. Veeramachaneni's members by 7.9 percentage points, from 2.1 percent to 10 percent. The SMART Aim measure goal of 10.0 percent was achieved, with the highest rate achieved being 100 percent. From June 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

The MCO set a goal of increasing the counseling for nutrition completion rate for Dr. Veeramachaneni's members by 7.2 percentage points, from 4.8 percent to 12 percent. The SMART Aim measure goal of 12.0 percent was achieved, with the highest rate achieved being 100 percent. From July 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

HPN set a goal of increasing the counseling for physical activity completion rate for Dr. Veeramachaneni's members by 7.3 percentage points, from 2.7 percent to 10 percent. The SMART Aim measure goal of 10.0 percent was achieved, with the highest rate achieved being 100 percent. From July 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

Upon initial validation of Module 5, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and its documentation related to how it will sustain improvement beyond the SMART Aim end date. HSAG provided technical assistance to **HPN** to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; and upon final validation, all of the validation criteria were met. Although the MCO exceeded the SMART Aim goal for all three measure components, this occurred prior to intervention testing and there was not a clear link between the

demonstrated improvement and all of the MCO's quality improvement activities. HSAG assigned a level of *Confidence* to the PIP.

Behavioral Health Hospital Readmissions PIP

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

HPN tested two interventions and submitted two Module 4s for validation.

The first intervention involved having the member and a nurse from **HPN** or Behavioral Health Options (BHO) establish the best location and method for post-discharge follow-up while the member was still inpatient. This intervention was predicted to increase the rate of the top 50 utilizers who were seen inpatient and who had consented to outpatient follow-up. The intervention was tested from July 19 through September 28, 2016. At the end of the testing period, the data were analyzed, and it was determined that only three members of the top 50 utilizers were able to be seen in the hospital by the nurse and agreed to outpatient care. Of the three members seen, one had an inpatient admission following consenting to outpatient follow-up care. **HPN** reported numerous challenges with this intervention; and although the SMART Aim run chart showed a reduction in readmissions during the testing period of this intervention, **HPN** could not attribute this reduction to the intervention. As a result, the MCO chose to abandon the intervention.

The second intervention involved enrolling the identified top 50 utilizers in the case management program. This program assists these high-need members with ongoing care and addresses the social barriers to receiving outpatient care. Educating and engaging the members and addressing the social determinants were predicted to reduce the number of hospitalizations. Testing took place from November 7, 2016, through February 24, 2017. According to the data collected, 13 of the top 50 utilizers consented to and became active in case management services. Nine members refused case management services, eight were unable to be contacted, and 20 were no longer eligible for services. When comparing the data from the run chart for the 13 members in case management from December to January, seven had no inpatient hospitalizations, three had an increase in the number of hospitalizations, and three had a decrease in the number of inpatient stays. **HPN** determined that it would adopt this intervention and expand it each month to a list of 50 members who had the most hospitalizations in the past year, were eligible for services, and were not currently enrolled in case management.

Upon initial validation of the first Module 4 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified opportunities for improvement with **HPN**'s summary of findings. The SMART Aim run chart included all of the top 50 utilizers. According to the Microsoft Excel sheet provided by the MCO, only three members accepted the intervention. Because the SMART Aim measure included members who did not receive the intervention, it would not be appropriate to use the SMART Aim measure to measure the effectiveness of the intervention. In addition, HSAG recommended that the MCO test the intervention longer to more accurately measure its success because the total number of members who received the intervention was very low. **HPN** made the necessary corrections to the module submission form and provided additional documentation. The MCO chose to abandon the

intervention due to numerous challenges. At the final validation of this module, **HPN** met all of the validation criteria.

Upon initial validation of the second Module 4 submitted for the *Behavioral Health Hospital Readmissions* PIP, **HPN** met all of the validation criteria and a resubmission was not required.

For sustainability, **HPN** determined Intervention 1 was not effective and therefore will not be pursued. For Intervention 2, **HPN** determined that active participation in BHO case management was successful in reducing hospital readmissions. The BHO was committed to continuing the intervention by expanding it to include a new monthly list of 50 non-active case management members with the most hospitalizations in the past year who are still eligible. In addition, the inpatient stays for those participating in case management will be tracked monthly to determine if there was an overall reduction.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–6—SMART Aim Measure Results for the Behavioral Health PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The percentage of inpatient substance abuse and/or mental health admissions for the identified top 50 utilizers.	13.8%	12.0%	Not Reportable	*Reported PIP results were not credible*

* The Lowest Rate Achieved is reported for the *Behavioral Health Hospital Readmissions* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

HPN established a goal of reducing the inpatient substance abuse and/or mental health admission rate for the identified top 50 utilizers by 1.8 percentage points, from 13.8 percent to 12.0 percent. HSAG was unable to determine if **HPN** was able to achieve the SMART Aim measure goal of 12.0 percent due to several confounding factors. HSAG observed that for calendar year (CY) 2016 the SMART Aim measure denominator nearly doubled, from 3,058 to 5,642, when compared with the baseline period of CY 2015. The difference in visits was an 84.5 percent increase. This trend continued beyond CY 2016 through the SMART Aim end date of March 2017. Over the same time period that the SMART Aim measure denominator nearly doubled, **HPN** reported that 20 of the top 50 utilizers were no longer eligible for the project, decreasing the total admissions for the numerator. The substantial increase in the SMART Aim measure denominator, combined with the decrease in the SMART Aim measure numerator, resulted in a decrease (improvement) in the SMART Aim measure independent of any interventions.

In addition to the changes that occurred with the SMART Aim measure numerator and denominator, **HPN** abandoned the top 50 super utilizer eligible population in November 2016 due to 20 of the 50 members no longer being eligible. The November 2016 newly identified top 50 super utilizers were no longer aligned with the SMART Aim measure and goal. The approved Module 1 and 2 methodology

required **HPN** to follow the original top 50 super utilizers through the SMART Aim end date, March 31, 2017. These factors affected HSAG's ability to determine if **HPN** achieved the SMART Aim goal through the tested interventions; therefore, the SMART Aim measure rate was entered as "Not Reportable."

Upon initial validation of Module 5, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and the execution of the PIP methodology. HSAG provided technical assistance to **HPN** to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; however, due to **HPN** changing the top 50 super utilizer eligible population and not executing the PIP as approved, not all validation criteria could be achieved despite the resubmission. HSAG assigned a level of *Reported PIP Results Were Not Credible* because the MCO did not execute the PIP as designed by **HPN** and approved by HSAG. **HPN** requested a rescoring of the PIP based on additional information **HPN** provided in a letter and teleconference meeting with HSAG; however, the MCO would have been required to recreate and resubmit Module 4 and Module 5 in order for HSAG to revalidate the PIP. Since the time period for resubmission had passed and SFY 2016-2017 was closed, DHCFP advised HSAG and **HPN** to close the PIP. To initiate the new PIPs for SFY 2017-2018, HSAG PIP team members have provided weekly technical assistance sessions with **HPN** staff members at **HPN**'s request.

Plan Comparison

The validation findings show that both MCOs were able to complete Module 4 successfully and attained *Achieved* scores across all evaluation elements. For Module 5, the validation findings and level of confidence assigned to the PIPs were mixed. **Amerigroup** received *Low Confidence* in the reported PIP results for both PIPs because the SMART Aim was not achieved. For **HPN**'s *WCC* PIP, the SMART Aim goal was achieved; however, this occurred prior to intervention testing. Therefore, there was no clear link between the demonstrated improvement and the MCO's quality improvement activities, and the PIP was assigned a level of *Confidence*. For the behavioral health PIP, **HPN** did not execute the PIP according to the HSAG-approved SMART Aim data collection methodology (Module 2); therefore, the PIP results were deemed not credible.

Summary of Recommendations

Based on the validation and outcome findings, HSAG offers the following recommendations:

- MCOs should execute improvement projects according to the approved methodology outlined in Module 2. If changes to the methodology are necessary, the MCO must contact HSAG to discuss the changes.
- MCOs should apply to future PIPs and quality improvement activities the identified lessons learned and knowledge gained from HSAG's feedback throughout the life of the PIP.

- MCOs should ensure that their core PIP teams include data analytical staff members who are involved in all data-related PIP processes for the life of the PIP.
- MCOs should complete an upfront analysis before testing an intervention. The MCOs should be able to gauge current performance, compare it to improved performance, and have a method of measuring the difference. By completing the upfront analysis, both of these objectives can be accomplished.
- MCOs should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.

7. CAHPS Surveys—SFY 2016–2017

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **HPN** and **Amerigroup** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their health care experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2017 CAHPS surveys for both **HPN** and **Amerigroup**.

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

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result was denoted as 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).

For each of the five composite scores and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive

or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Plan-Specific Findings—Amerigroup

Table 7–1 shows **Amerigroup**'s 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 2,430 adult members were administered a survey, of which 471 completed a survey. After ineligible members were excluded, the response rate was 19.8 percent. In 2016, the average NCQA response rate for the adult Medicaid population was 24.8 percent, higher than **Amerigroup**'s response rate.[7-1]

Table 7–1—Amerigroup Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	77.6%	75.7%
Getting Care Quickly	76.4%	76.8%
How Well Doctors Communicate	87.5%	87.0%
Customer Service	84.7%	89.5%
Shared Decision Making	80.0%	75.4%
Global Ratings		
Rating of All Health Care	44.2%	44.8%
Rating of Personal Doctor	58.6%	58.3%
Rating of Specialist Seen Most Often	58.6%	58.2%
Rating of Health Plan	45.9%	48.4%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	62.6%	64.8%
Discussing Cessation Medications	34.8%	36.7%
Discussing Cessation Strategies	32.6%	29.9%

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

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

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

Amerigroup's rates decreased between 2016 and 2017 for six of 12 measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*. **Amerigroup**'s rates increased between 2016 and 2017 for six measures: *Getting Care Quickly*, *Customer Service*, *Rating of All Health*

[7-1] 2017 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Care, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, and *Discussing Cessation Medications*. None of the measure rates had a substantial increase or decrease from the 2016 rate.

Amerigroup's 2017 top-box rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, seven measures were at least 5 percentage points less than the 2016 national averages: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Table 7–2 shows **Amerigroup**'s 2016 and 2017 general child Medicaid CAHPS top-box rates.[7-2] In 2017, a total of 4,042 general child members were administered a survey, of which 783 completed a survey.[7-3] After ineligible members were excluded, the response rate was 19.6 percent. In 2016, the average NCQA response rate for the child Medicaid population was 23.0 percent, higher than **Amerigroup**'s response rate.[7-4]

Table 7–2—Amerigroup General Child Medicaid CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	77.5%	77.1%
Getting Care Quickly	83.3%	80.7%
How Well Doctors Communicate	88.5%	89.9%
Customer Service	87.2%	87.0%
Shared Decision Making	77.3%	78.7%
Global Ratings		
Rating of All Health Care	68.6%	66.3%
Rating of Personal Doctor	69.2%	72.4%
Rating of Specialist Seen Most Often	80.0%	70.9%
Rating of Health Plan	64.5%	70.2%

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

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

Amerigroup's rates increased between 2016 and 2017 for four measures: *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. None of these rates showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2016 and 2017 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of all Health Care*, and *Rating of Specialist Seen Most Often*. Of these, *Rating of Specialist Seen Most Often* showed a substantial decrease of more than 9 percentage points.

Amerigroup's 2017 top-box rates for the general child Medicaid population were lower than the 2016 NCQA child Medicaid national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of*

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

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

[7-4] 2017 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Personal Doctor, and *Rating of Specialist Seen Most Often*. Of these, two measures were at least 5 percentage points less than the 2016 national average: *Getting Needed Care* and *Getting Care Quickly*. Two measures were greater than the 2016 national average: *Shared Decision Making* and *Rating of Health Plan.* None of these measures, however, were at least 5 percentage points greater than the 2016 national averages.

Table 7–3 shows **Amerigroup**'s 2016 and 2017 CCC Medicaid CAHPS top-box rates.[7-5] In 2017, a total of 259 child members with a chronic condition completed a survey.[7-6]

Table 7–3—Amerigroup CCC Medicaid CAHPS Results

	2016 CCC Supplemental Top-Box Rates	2017 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	79.4%	79.6%
Getting Care Quickly	81.9%	86.0%
How Well Doctors Communicate	89.8%	92.6%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	62.6%	65.0%
Rating of Personal Doctor	69.2%	75.1%
Rating of Specialist Seen Most Often	72.6%	72.1%
Rating of Health Plan	61.4%	65.2%
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	89.7%	87.6%
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	79.2%	85.1%
FCC: Getting Needed Information	88.5%	90.6%

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).

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

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

Amerigroup's rates increased between 2016 and 2017 for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Rating of Personal Doctor* and *Access to Prescription Medicines* showed a substantial increase of more than 5 percentage points. **Amerigroup's** rates decreased between 2016 and 2017 for two reportable measures: *Rating of Specialist Seen Most Often* and *FCC: Personal Doctor Who Knows Child*. None of these measure rates had a substantial decrease from the 2016 rate.

Amerigroup's 2017 top-box rates for the CCC population were lower than the 2016 NCQA CCC child Medicaid national averages for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Health Plan*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, three measures were at least 5 percentage points less than the 2016 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*.

Table 7–4 shows **Amerigroup's** 2016 and 2017 Nevada Check Up CAHPS top-box rates.[7-7] Since NCQA does not publish separate rates for the Children's Health Insurance Program (CHIP), national comparisons could not be made. In 2017, a total of 1,377 Nevada Check Up general child members were administered a survey, of which 348 completed a survey.[7-8] After ineligible members were excluded, the response rate was 25.9 percent.

Table 7–4—Amerigroup Nevada Check Up CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	76.5%	76.6%
Getting Care Quickly	81.6%	82.0%
How Well Doctors Communicate	90.8%	93.5%
Customer Service	84.5%	NA
Shared Decision Making	78.3%	NA
Global Ratings		
Rating of All Health Care	60.3%	68.3%
Rating of Personal Doctor	72.7%	74.4%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	68.6%	68.2%

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

Amerigroup's rates decreased between 2016 and 2017 for one reportable measure, *Rating of Health Plan.* Between 2016 and 2017, the rates increased for five reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*. None of the measure rates had a substantial increase or decrease from the 2016 rate.

Table 7-5 shows **Amerigroup**'s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the CCC population.[7-9] Since NCQA does not publish separate rates for the CHIP program, national comparisons

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

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

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

could not be made. In 2017, a total of 73 Nevada Check Up child members with a chronic condition completed a survey.[7-10]

Table 7–5—Amerigroup CCC Nevada Check Up CAHPS Results

	2016 CCC Supplemental Top-Box Rates	2017 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	NA	NA
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	NA
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	NA	NA
Rating of Personal Doctor	NA	NA
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	NA	NA
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA	NA
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	NA	NA
FCC: Getting Needed Information	NA	NA

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

Amerigroup's 2016 and 2017 rates could not be reported for the Nevada Check Up CCC population since all measures did not meet the minimum number of responses.

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

Plan-Specific Findings—HPN

Table 7–6 shows **HPN**'s 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 1,890 members were administered a survey, of which 276 completed a survey. After ineligible members were excluded, the response rate was 14.8 percent. In 2016, the average NCQA response rate for the adult Medicaid population was 24.8 percent, higher than **HPN**'s response rate.[7-11]

Table 7–6—HPN Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	73.1%	76.1%
Getting Care Quickly	70.4%	75.9%
How Well Doctors Communicate	86.5%	85.6%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	44.6%	48.7%
Rating of Personal Doctor	54.3%	56.3%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	52.5%	49.4%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	63.1%	63.0%
Discussing Cessation Medications	24.8%	22.4%
Discussing Cessation Strategies	26.8%	19.9%

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

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

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

HPN's rates decreased between 2016 and 2017 for five of nine reportable measures: *How Well Doctors Communicate*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, one measure showed a substantial decrease of more than 5 percentage points: *Discussing Cessation Strategies*. Four measures increased between 2016 and 2017: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health*

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

Care, and *Rating of Personal Doctor*. Of these, *Getting Care Quickly* showed a substantial increase of more than 5 percentage points.

HPN's 2017 top-box rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, *and Discussing Cessation Strategies*. Of these, six measures were at least 5 percentage points less than the 2016 national average: *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Table 7–7 shows **HPN**'s 2016 and 2017 child Medicaid CAHPS top-box rates.[7-12] In 2017, a total of 2,310 general child members were administered a survey, of which 332 completed a survey.[7-13] After ineligible members were excluded, the response rate was 14.5 percent. In 2016, the average NCQA response rate for the child Medicaid population was 23.0 percent, higher than **HPN**'s response rate.[7-14]

Table 7–7—HPN General Child Medicaid CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	80.6%	84.3%
Getting Care Quickly	85.9%	86.1%
How Well Doctors Communicate	89.5%	92.4%
Customer Service	90.1%	NA
Shared Decision Making	78.4%	NA
Global Ratings		
Rating of All Health Care	68.5%	62.1%
Rating of Personal Doctor	74.4%	77.6%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	74.9%	75.3%

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

Indicates the 2017 rate is at least 5 percentage points greater than the 2016 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

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

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

[7-14] 2017 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

HPN's rates decreased between 2016 and 2017 for one of the six reportable measures: *Rating of All Health Care*. The decrease was more than 5 percentage points. **HPN**'s rates increased between 2016 and 2017 for five reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, no measures showed a substantial increase of more than 5 percentage points.

HPN's 2017 top-box rates for the general child Medicaid population were lower than the 2016 NCQA general child Medicaid national averages for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. Three of **HPN**'s 2017 top-box rates for the general child Medicaid population were higher than the 2016 NCQA general child Medicaid national average: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. *Rating of Health Plan* was at least 5 percentage points greater than the 2016 national average.

Table 7–8 shows **HPN**'s 2016 and 2017 CCC Medicaid CAHPS top-box rates.[7-15] In 2017, a total of 199 child members with a chronic condition completed a survey.[7-16]

Table 7–8—HPN CCC Medicaid CAHPS Results

	2016 CCC Supplemental Top-Box Rates	2017 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	76.5%	77.8%
Getting Care Quickly	85.0%	89.9%
How Well Doctors Communicate	91.8%	91.1%
Customer Service	NA	NA
Shared Decision Making	78.7%	NA
Global Ratings		
Rating of All Health Care	64.9%	59.6%
Rating of Personal Doctor	68.9%	74.1%
Rating of Specialist Seen Most Often	63.2%	NA
Rating of Health Plan	66.8%	68.0%
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	88.6%	86.7%

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

	2016 CCC Supplemental Top-Box Rates	2017 CCC Supplemental Top-Box Rates
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	89.1%	92.7%
FCC: Getting Needed Information	87.3%	87.7%

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

Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

HPN's rates increased between 2016 and 2017 for six reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, one measure showed a substantial increase of more than 5 percentage points: *Rating of Personal Doctor*. **HPN**'s rates decreased between 2016 and 2017 for three reportable measures: *How Well Doctors Communicate*, *Rating of All Health Care*, and *FCC: Personal Doctor Who Knows Child*. Of these, one measure showed a substantial decrease of more than 5 percentage points: *Rating of All Health Care*.

HPN's 2017 top-box rates for the CCC population were lower than the 2016 NCQA CCC national average for seven reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *FCC: Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information*. Two of **HPN**'s 2017 top-box rates for the CCC child Medicaid population were higher than the 2016 NCQA CCC national average: *Rating of Health Plan* and *Access to Prescription Medicines*. However, two measures were at least 5 percentage points less than the 2016 national average: *Getting Needed Care* and *Rating of All Health Care.*

Table 7–9 shows **HPN**'s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the general child population.[7-17] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2017, a total of 1,650 Nevada Check Up general child members were surveyed and 378 completed a survey.[7-18] After ineligible members were excluded, the response rate was 23.1 percent.

[7-17] The Nevada Check Up CAHPS results presented in Table 7-9 for HPN are based on the results of the general child population only.

[7-18] The total number of members surveyed and who completed surveys is based on HPN's general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

Table 7–9—HPN Nevada Check Up CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	79.6%	79.1%
Getting Care Quickly	82.2%	86.0%
How Well Doctors Communicate	89.7%	93.1%
Customer Service	85.2%	NA
Shared Decision Making	73.8%	NA
Global Ratings		
Rating of All Health Care	66.6%	68.1%
Rating of Personal Doctor	73.5%	72.6%
Rating of Specialist Seen Most Often	68.4%	NA
Rating of Health Plan	73.9%	73.2%

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

HPN's rates increased between 2016 and 2017 for three reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. **HPN**'s rates decreased between 2016 and 2017 for the remaining three reportable measures: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. No measures showed a substantial increase or decrease of more than 5 percentage points between 2016 and 2017.

Table 7–10 shows **HPN**'s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the CCC population.[7-19] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2017, 151 Nevada Check Up child members with a chronic condition completed a survey.[7-20]

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

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

Table 7–10—HPN CCC Nevada Check Up CAHPS Results

	2016 CCC Supplemental Top-Box Rates	2017 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	80.9%	77.5%
Getting Care Quickly	84.2%	NA
How Well Doctors Communicate	90.7%	93.8%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	67.2%	62.5%
Rating of Personal Doctor	73.1%	75.0%
Rating of Specialist Seen Most Often	70.6%	NA
Rating of Health Plan	67.8%	65.8%
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	86.7%	NA
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	87.7%	90.0%
FCC: Getting Needed Information	88.4%	91.3%

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

HPN's rates increased between 2016 and 2017 for four reportable measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. **HPN**'s rates decreased between 2016 and 2017 for three measures: *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan*. No measures showed a substantial increase or decrease of more than 5 percentage points between 2016 and 2017.

Plan Comparison

HPN's adult Medicaid CAHPS scores were below the 2016 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **HPN**'s response rate for the 2017 adult Medicaid population was 10 percentage points lower than the 2016 NCQA adult Medicaid average response rate. **Amerigroup**'s adult Medicaid CAHPS scores were below the 2016 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **Amerigroup**'s response rate for the adult Medicaid population was lower than the 2016 NCQA adult Medicaid average response rate by 5 percentage points.

HPN's general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for two reportable composite measures: *Getting Care Quickly* and *How Well Doctors Communicate*, and for one reportable global rating: *Rating of All Health Care*. **HPN**'s response rate for the 2017 general child Medicaid population was lower than the 2016 NCQA general child Medicaid average response rate by 8.5 percentage points. **Amerigroup**'s general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for four composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. In addition, **Amerigroup**'s general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for three global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. **Amerigroup**'s response rate for the general child Medicaid population was 3.4 percentage points lower than the average 2016 NCQA response rate for the general child Medicaid population.

HPN's CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. **HPN**'s CCC child Medicaid CAHPS scores were also below the 2016 NCQA CCC child Medicaid national averages for two reportable global ratings: *Rating of All Health Care* and *Rating of Personal Doctor*. In addition, **HPN**'s CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for two reportable CCC composite measures: *FCC: Personal Doctor Who Knows Child* and *FCC: Getting Needed Information*. **Amerigroup**'s CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, **Amerigroup**'s CCC child Medicaid CAHPS scores were also below the 2016 NCQA CCC child Medicaid national averages for two global ratings: *Rating of All Health Care* and *Rating of Health Plan*, and for three reportable CCC composite measures: *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*.

HPN's 2017 Nevada Check Up CAHPS scores were below the 2016 Nevada Check Up CAHPS scores for three reportable measures for the general child population: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s 2017 Nevada Check Up CAHPS scores were above the 2016 Nevada Check Up CAHPS scores for five reportable measures for the general child population: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

HPN's 2017 Nevada Check Up CCC CAHPS score was below the 2016 Nevada Check Up CCC CAHPS score for one composite measure: *Getting Needed Care*. **HPN**'s 2017 Nevada Check Up CCC CAHPS score was also below the 2016 Nevada Check Up CCC CAHPS score for two global ratings: *Rating of All Health Care* and *Rating of Health Plan*. **Amerigroup**'**s** 2017 Nevada Check Up CCC CAHPS survey results were lower than the minimum required 100 responses; therefore, the comparisons could not be completed. Additionally, since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

Conclusions and Recommendations

Amerigroup

HSAG recommends that **Amerigroup** continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum 100 responses for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*, since these rates were lower than the 2016 adult CAHPS results and fell below NCQA's 2016 CAHPS adult Medicaid national averages.

For the general child Medicaid population, **Amerigroup** should focus on improving *Rating of Specialist Seen Most Often*, since the rate for this measure was substantially lower than the 2016 general child CAHPS results and fell slightly below NCQA's 2016 CAHPS child Medicaid national averages. Interventions targeted at the provider level for this measure likely will have the greatest impact on the measure. Additionally, efforts should focus on improving *Getting Needed Care* and *Getting Care Quickly*, since these rates were substantially lower than the NCQA's 2016 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus on improving *FCC: Personal Doctor Who Knows Child*, since the rate for this reportable measure was lower than the 2016 CCC child CAHPS results and fell below NCQA's 2016 CAHPS CCC child Medicaid national average. In addition, **Amerigroup** should look to improve *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*, since the rates for these measures were substantially lower than the

2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*, since the 2017 rate for this reportable measure was lower than the 2016 rate.

CAHPS measures like *Getting Needed Care* and *Getting Care Quickly* are access-related and lower rates indicate a perception that members cannot obtain needed care with providers or that members cannot obtain services as quickly as desired. **Amerigroup**'s 2016 Annual Quality Evaluation described the efforts the MCO employed to expand the network to include additional providers and provider relations consultants (See Section 9 for more information). HSAG encourages **Amerigroup** to evaluate those interventions to determine if they are having the desired effect. For the remaining CAHPS measures that fell below the Medicaid national averages (*How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*), interventions targeted at the provider level and provider communication and interaction with Medicaid members most likely will have the greatest impact on the measures.

HPN

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

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *How Well Doctors Communicate*, *Rating of Health Plan*, *Rating of a Personal Doctor*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the NCQA's 2016 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *Rating of All Health Care*, since the rate was lower than the 2016 child CAHPS result and fell below NCQA's 2016 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Rating of All Health Care*, since the rates for these measures were substantially lower than the 2016 NCQA CCC child Medicaid national averages. In addition, **HPN** should look to improve on *How Well Doctors Communicate* and *FCC: Personal Doctor Who Knows Child*, since the rates were lower than the 2016 CCC child Medicaid results and fell below the 2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, **HPN** should focus quality improvement efforts on *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these measures showed a slight decrease from 2016 to 2017. For the CCC Nevada Check Up population, **HPN** should improve on *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan*, since the rates for these measures decreased from 2016 to 2017.

The **HPN** 2016 Quality Improvement Evaluation described several interventions the MCO deployed to improve CAHPS rates. Those included expanding the Medicaid network and encouraging providers to use the automated referral application to reduce the turnaround time for referrals to specialists. These interventions have the greatest likelihood of impacting access-related CAHPS measures like *Getting Needed Care* and *Getting Care Quickly*. CAHPS measures like *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, *Discussing Cessation Strategies*, and *Rating of Personal Doctor* would be most affected by targeting interventions at the provider level. The **HPN** 2016 Quality Improvement Evaluation described **HPN**'s intervention to conduct monthly patient satisfaction surveys to identify poor performing providers who may be referred to the health plan's Credentialing Committee. HSAG encourages **HPN** to evaluate the effectiveness of the intervention and use survey data collected from monthly surveys to advise and educate providers on ways to improve interactions with Medicaid members.

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

Background

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

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

The DHCFP sought to verify that **APH** collected and reported complete and accurate performance measure data annually for contractually required performance measures. To that end, the DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates that **APH** calculated and reported. HSAG validated **APH**'s performance measures using the CMS external quality review (EQR) Protocol 2[9-1] as its guide to ensure the performance measure validation (PMV) activity was performed in accordance with industry standards of practice. HSAG's PMV activity focused on the following objectives:

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

Performance Measure Validated

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

[9-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jul 18, 2017.

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

Validation Results

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

Data Retrieval

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

Data Integration

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

Data Control

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

Source Code Development and Performance Measure Documentation

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

Performance Measure-Specific Rates

On October 18, 2016, HSAG received the final performance measure results generated by **APH** based on the latest receipt of all applicable monthly operational files. All measure results were reviewed for

reasonability. Table 8-1 shows the measure-specific rates for **APH** for program period 2 (June 1, 2015, through May 30, 2016).

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

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
CCHU.1	*Ambulatory Care-Sensitive Condition Hospital Admission (per 100,000 population)*	2713	60781	4463.57	**Reportable**
CCHU.2	*"Avoidable" ER Visits*	20332	62881	32.3%	**Reportable**
FUP	*Follow-Up with PCP After Hospitalization*	1706	5337	32.0%	**Reportable**
MRP	*Medication Reconciliation Post-Discharge*	54	5337	1.0%	**Reportable**
DEM	*Cognitive Assessment for Dementia*	8	349	2.3%	**Reportable**
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*	8	83	9.6%	**Reportable**
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*	0	549	0.0%	**Reportable**
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*	142	208	68.3%	**Reportable**
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*	19	436	4.4%	**Reportable**
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***BMI total***	0	9927	0.0%	**Reportable**
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. (12–17 Years)* ***BMI total***	114	6255	1.8%	**Reportable**
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***Counseling for Nutrition Total***	237	9927	2.4%	**Reportable**
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years)* ***Counseling for Nutrition Total***	151	6255	2.4%	**Reportable**
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***Counseling for Physical Activity Total***	54	9927	0.5%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
OBS	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years)* ***Counseling for Physical Activity Total***	44	6255	0.7%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–24 months)*	958	1081	88.6%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years)*	5193	6951	74.7%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (7–11 years)*	7051	8374	84.2%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–19 years)*	10065	12140	82.9%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (0 Visits)*	186	1067	17.4%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (1 Visit)*	112	1067	10.5%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (2 Visits)*	111	1067	10.4%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (3 Visits)*	108	1067	10.1%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (4 Visits)*	120	1067	11.2%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (5 Visits)*	119	1067	11.2%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (6 or more visits)*	311	1067	29.1%	**Reportable**
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	2398	5902	40.6%	**Reportable**
AWC	*Adolescent Well-Care Visits*	3227	13868	23.3%	**Reportable**
CIS	*Childhood Immunization Status (Dtap)*	612	1139	53.7%	**Reportable**
CIS	*Childhood Immunization Status (IPV)*	832	1139	73.0%	**Reportable**
CIS	*Childhood Immunization Status (MMR)*	815	1139	71.6%	**Reportable**
CIS	*Childhood Immunization Status (HiB)*	799	1139	70.1%	**Reportable**
CIS	*Childhood Immunization Status (HepB)*	829	1139	72.8%	**Reportable**
CIS	*Childhood Immunization Status (VZV)*	807	1139	70.9%	**Reportable**
CIS	*Childhood Immunization Status (PCV)*	622	1139	54.6%	**Reportable**
CIS	*Childhood Immunization Status (HepA)*	817	1139	71.7%	**Reportable**
CIS	*Childhood Immunization Status (Rotavirus)*	771	1139	67.7%	**Reportable**
CIS	*Childhood Immunization Status (Influenza)*	333	1139	29.2%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
CIS	*Childhood Immunization Status (Combination #2)*	583	1139	51.2%	**Reportable**
CIS	*Childhood Immunization Status (Combination #3)*	531	1139	46.6%	**Reportable**
CIS	*Childhood Immunization Status (Combination #4)*	531	1139	46.6%	**Reportable**
CIS	*Childhood Immunization Status (Combination #5)*	477	1139	41.9%	**Reportable**
CIS	*Childhood Immunization Status (Combination #6)*	241	1139	21.2%	**Reportable**
CIS	*Childhood Immunization Status (Combination #7)*	477	1139	41.9%	**Reportable**
CIS	*Childhood Immunization Status (Combination #8)*	241	1139	21.2%	**Reportable**
CIS	*Childhood Immunization Status (Combination #9)*	211	1139	18.5%	**Reportable**
CIS	*Childhood Immunization Status (Combination #10)*	211	1139	18.5%	**Reportable**
PPC	*Timeliness of Prenatal Care*	234	856	27.3%	**Reportable**
PPC	*Postpartum Care*	116	856	13.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, <21 percent of expected visits*	541	856	63.2%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 21 percent–40 percent of expected visits*	181	856	21.1%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 41 percent–60 percent of expected visits*	91	856	10.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 61 percent–80 percent of expected visits*	23	856	2.7%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, ≥81 percent of expected visits*	20	856	2.3%	**Reportable**
ABA	*Adult BMI Assessment*	2859	23466	12.2%	**Reportable**
BCS	*Breast Cancer Screening*	3138	9980	31.4%	**Reportable**
CCS	*Cervical Cancer Screening*	5579	18409	30.3%	**Reportable**
COL	*Colorectal Cancer Screening*	2444	11765	20.8%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization.* *1–12 weeks (279–196 days prior to delivery)*	140	1321	10.6%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization.* *13–27 weeks (195–91 days prior to delivery)*	424	1321	32.1%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization.* *28 or more weeks of pregnancy (<=90 days prior to delivery)*	610	1321	46.2%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. <=0 weeks (280 days or more prior to delivery)*	83	1321	6.3%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. Unknown*	64	1321	4.8%	**Reportable**

Summary of Findings

This audit reviewed 22 performance measures. All were determined to be reportable by **APH** for the reporting period under review; however, there were several issues identified during the on-site audit.

It was determined that for the first program period (June 1, 2014, through May 30, 2015), all indicators (numerators) for the *Childhood Immunization Status* measure were underreported and based solely on administrative data. Without immunization data from the State registry or medical record review, the measure's rates were too low to derive effective conclusions. The State provided **APH** with the immunization registry data for both program periods during the second period (June 1, 2015, through May 30, 2016). **APH** calculated the current program period immunization rates and recalculated the rates for the first period. The rates for both program periods were approved.

For the *Stroke and Stroke Rehabilitations–Discharged on Antithrombotic Therapy (NEUR)* measure, the denominator remained low for the second program period. Members in the denominator must have been in the HCGP program the entire period. The numerator only included members who were discharged on antithrombotic therapy.

The *Adult Kidney Disease–Laboratory Testing (CKD)* measure evaluated whether a member with kidney disease had a fasting lipid profile completed during the program year. The rate provided by **APH** was 0.00 percent. A line-by-line evaluation of the source code identified that the code aligned with the technical specifications. However, the auditor determined the technical specifications did not include the most common CPT code (80061) used for the fasting lipid profile. During the on-site visit, **APH** re-calculated the measure to determine the impact of the missing code 80061. The results of the re-calculation increased the rate to more than 77 percent.

During the first program year for the *Cognitive Assessment for Dementia (DEM)* measure, **APH** was not able to fully identify the denominator. **APH** applied the State-allowed changes to the denominator code, which improved the identification of dementia. However, the numerator for this measure continued to be problematic for **APH**. The **APH** providers were not submitting claims that incorporated the CPT code

for the assessment. Since the members with dementia were identified, it is likely the majority of those members who were identified had an assessment completed.

The weight assessment body mass index (BMI) component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both age groups (3–11 and 12–18 years) had no administrative data and was reported as 0.0 percent. The source code appeared to use the adult BMI code set instead of the child BMI code set. During the on-site visit, **APH** corrected its source code and the new rates were considered reportable. The auditor also noted the rates produced by Milliman were low.

As identified during the first program year's audit, the rates for *Timeliness of Prenatal Care, Postpartum Care*, and *Frequency of Ongoing Prenatal Care* were very low compared to national percentiles. These rates may have been impacted by global billing practices. Global billing is the submission of a single claim for a fixed fee that covers all care related to a certain condition over a particular period, such as billing for prenatal and postpartum care visits in conjunction with the delivery. Since generally only global billing is submitted for the duration of a woman's pregnancy, performance measures could be underreported without medical record abstraction to augment records found to be numerator-compliant. *Timeliness of Prenatal Care, Postpartum Care*, and *Frequency of Ongoing Prenatal Care* rates were considered reportable since the calculation of the measures met the technical specifications and a true underreported bias could not be ascertained during the audit.

Overall Recommendations and Status of Recommendations

As a result of the HCGP performance measure validation, HSAG made several recommendations to the DHCFP and **APH** so that measures could be fully reported. Below are those recommendations as well as a status update on them.

- HSAG recommended that the DHCFP examine the technical specification for the *CKD* measure and consider adding the CPT code 80061. The DHCFP also should review all other codes available for this measure and add other appropriate fasting lipid profiles codes to enhance the technical specification for the measure.
- **APH** experienced challenges in capturing numerator-positive cases for the *DEM* measure due to providers not submitting claims for the assessment. HSAG recommended that **APH** consider implementing additional provider training or payment methodologies to capture completed assessments administratively.
- HSAG recommended the DHCFP ensure that **AHP** correct its source code to include the child BMI code set for the weight assessment BMI component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both 3–11 and 12–18 age groups.
  - **Update**: During the on-site visit, **APH** corrected its source code to include the child BMI code set and recalculated its rates. The newly calculated rates were considered reportable.

Based on the audit findings, HSAG recommended that the technical specifications for all measures be reviewed annually by the DHCFP, or at a minimum every other year in order to ensure that the codes were valid and complete. The review of the technical specifications should also consider prior audit findings and current medical and/or clinical practices.

9. Follow-Up on Recommendations

Introduction

This section of the EQR technical report presents an assessment of how effectively the MCOs addressed the recommendations that HSAG made based on the results of the previous year's EQR activities. Since compliance review activities were not performed in SFY 2015–2016, there were no recommendations related to compliance.

The DHCFP established a collaborative environment to promote sharing of information about emerging practices identified by the MCOs, which would take place at a quarterly on-site meeting that includes MCO, DHCFP, and HSAG staff members as well as external stakeholders. The collaborative sharing among the staffs from the DHCFP and the MCOs promotes continual quality improvement of the Nevada Medicaid and Nevada Check Up programs, and it has enabled the DHCFP to track progress toward meeting the goals and objectives identified in the DHCFP's quality strategy. Each health plan is responsible for identifying, through routine data analysis and evaluation, quality improvement initiatives that support improvement in quality, access, and timeliness of services delivered to Medicaid members. By testing the efficacy of these initiatives over time, the MCOs have the ability to determine which of them yield the greatest improvement.

It is at these collaborative quarterly meetings that MCOs present the results of data analyses and evaluations that address recommendations made by HSAG. MCOs also present the interventions and initiatives that have yielded success for their membership and, consequently, performance measure rates. Presented below is a summary of how the MCOs addressed the recommendations that HSAG made based on the previous year's EQR activities.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Presentation of Emerging Practices

The SFY 2015–2016 EQR technical report summarized emerging practices and opportunities for improvement for both MCOs. Emerging practices and improvement were defined as a 5 percentage point or greater improvement in rates from HEDIS 2015 to HEDIS 2016. For those performance measures, MCOs were asked to present the types of interventions and quality improvement initiatives used to positively impact the Medicaid and Nevada Check Up performance measure rates and ultimately improve access to care and quality and timeliness of care.

Amerigroup Actions Taken

In January 2017, **Amerigroup**'s staff presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Medicaid performance measures:

- *Annual Dental Visit—Total*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5, 7*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Amerigroup's staff also presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Nevada Check Up performance measures:

- *Childhood Immunization Status—Combinations 2, 5, 7, 9, 10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

Overall, **Amerigroup** found that member and provider reminders were very successful in prompting members to receive required screenings, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and wellness visits, which had the potential to improve quality and timeliness of care. **Amerigroup** reported the use of interactive automated voice response systems as an effective method for the reminders. **Amerigroup** also used a series of texting campaigns to communicate with members and it continued its member and provider incentive programs. Additionally, **Amerigroup** had increased its provider relations consultants in an effort to contract with more providers and expand it network, which had the potential to improve availability of providers.

HPN Actions Taken

In January 2017, **HPN**'s staff presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Medicaid performance measures:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*
- *Adolescent Well-Care Visits*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

HPN's staff also presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Nevada Check Up performance measures:

- *Childhood Immunization Status—Combinations 3, 4, 5, 7, 9, and 10*

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

HPN's staff reported that by promoting the use of extended office hours for primary care physician offices and urgent care, members were more likely to seek care in more appropriate settings as well as obtain wellness checks and age-appropriate screenings. Extended office hours helped to improve access and availability of services as well as quality and timeliness of care by promoting wellness and preventive care. **HPN** also reported the use of member and provider incentives to promote health and wellness screenings.

Opportunities for Improvement

The SFY 2015–2016 EQR technical report summarized opportunities for improvement for both MCOs. Opportunities were defined as a 5 percentage-point or greater decline in rates from HEDIS 2015 to HEDIS 2016. For those performance measures, HSAG recommended that the MCOs conduct causal barrier analyses and identify the interventions that were planned to overcome those barriers. HSAG asked MCOs to present the analyses in the January 2017 quarterly meeting. Specifically, MCOs were asked to prepare presentations addressing the interventions that would improve performance as well as those that had been discontinued due to lack of improvement. MCOs also were asked to present the evaluation plan put in place to evaluate the effectiveness of each planned intervention.

Amerigroup Actions Taken

In January 2017, **Amerigroup** staff members presented the barrier analysis and planned improvement strategies for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, the Medicaid performance measure that declined in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016. There were no other performance measures that declined by 5 percentage points or more from HEDIS 2015 to HEDIS 2016 for either Medicaid or Nevada Check Up.

While the causes of the decline may have been attributed to changes in the technical specifications for the measure, **Amerigroup** conducted an analyses of the interventions it used for this and other measures. **Amerigroup** staff members reported that outreach phone calls alone were not effective; however, if the automated phone calls were paired with letter or postcard reminders, the interventions were more effective. **Amerigroup** also enrolled more people in the diabetes disease management program, which increased enrollment from 2,786 members in the first quarter of 2016 to 3,673 members in the fourth quarter of 2016. Members enrolled in the disease management program will have access to additional information and services that are condition-specific and improve the quality of care they receive by educating them on the importance of self-care and allowing them to effectively manage their health care needs. **Amerigroup** staff members reported that the interventions would be monitored through the collection of HEDIS data and member feedback.

HPN Actions Taken

In January 2017, **HPN** staff members presented the barrier analysis and planned improvement strategies for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg,)* the Medicaid performance measure that declined in performance more than 5 percentage points from HEDIS 2015 to HEDIS 2016. There were no other performance measures that declined by 5 percentage points or more from HEDIS 2015 to HEDIS 2016 for either Medicaid or Nevada Check Up.

While the causes of the decline may have been attributed to changes in the technical specifications for the measure, **HPN** conducted an analyses of the interventions it used for this and other measures. The **HPN** 2016 Quality Improvement Program Evaluation included information about the evaluation of outreach calls to members and noted that Medicaid members were not as likely to be home during the day when the staff made the outreach calls. During the January 2017 presentation, **HPN** staff members reported that the MCO increased the number of health, education, and wellness classes offered to members with diabetes. The MCO also increased the amount of member case management education and outreach to address gaps in care and address preventive care services that had not been accessed by the member, enabling the member to be the driver in obtaining quality-related services.

Performance Improvement Projects

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations at the time of resubmission, HSAG did not have recommendations for the PIP modules that were submitted, approved, and reported on in the SFY 2015–2016 EQR Technical Report.

CAHPS Surveys

The SFY 2015–2016 EQR Technical Report offered recommendations for the MCOs as they prioritized their performance improvement initiatives. HSAG recommended that both MCOs work with the respective CAHPS vendor to obtain a sufficient number of completed surveys so that all measures could be reported. HSAG recommendations to improve rates for quality and access-related CAHPS measures are detailed below.

Amerigroup Recommendations

For **Amerigroup**'s Medicaid population, HSAG recommended that the MCO focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making.* For the CCC Medicaid population, **Amerigroup** should focus on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information.* For the Nevada Check Up population, HSAG recommended that **Amerigroup** focus quality improvement initiatives on enhancing members'

experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*.

Amerigroup Actions Taken

Amerigroup formed a cross-functional committee supported by representation from each of the quality departments. The committee reviewed results of the CAHPS scores and also reviewed the analysis the vendor provided. The committee found that some possible barriers to access were related to the physician network and characteristics of providers as well as member ethnicity, location of the provider, and membership as well as individual knowledge of health plan systems. The committee completed a barrier analysis and identified possible root causes regarding access issues. It also identified opportunities to overcome the barriers. With the Medicaid expansion population, the health plan saw a large rise in membership year over year. The committee surmised that this may have strained the existing network, resulting in a need for additional providers and for provider relations consultants to service the entire network. **Amerigroup** contracted with additional providers and hired additional provider relations consultants in early 2016. The consultants continued to review the network to determine if gaps existed in the presence of provider locations and specialties. If any gaps in the network were identified, the provider relations consultants initiated the contracting process with new providers.

HPN Recommendations

HSAG recommended that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population. For the general child Medicaid population, HSAG recommended that **HPN** focus on improving *How Well Doctors Communicate*. For the CCC child Medicaid population, HSAG recommended that **HPN** focus on improving *Getting Needed Care* and *Shared Decision Making*, and for the Nevada Check Up population it recommended that quality improvement efforts should focus on *Shared Decision Making*. For the CCC Nevada Check Up population, HSAG recommended that **HPN** improve *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*.

HPN Actions Taken

HPN evaluated the results from its CAHPS survey and identified a set of interventions and activities to improve CAHPS rates. Specifically, **HPN**:

- Encouraged providers to use the automated referral application. This process reduced the turnaround time for referrals to specialists in order to improve access to medically necessary specialized services.
- Expanded the Medicaid physician network to increase the availability and access to care.

- Conducted follow-up phone calls to members who accessed the emergency room for what appeared to be nonemergent medical conditions. **HPN** provided information on accessing urgent care and establishing a medical home with a primary care physician.
- Conducted monthly patient satisfaction surveys to identify poor-performing providers who may be referred to the health plan's credentialing committee.

Appendix A. Technical Methods of Data Collection and Analysis

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

From all of the data collected, HSAG summarizes each MCO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each MCO provides. The evaluations are based on the following definitions of quality, access, and timeliness:

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement."[A-1]

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

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A-2] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care)."

- ***Access***—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness

[A-1] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

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

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

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

Internal Quality Assurance Program (IQAP)

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada and all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 technical report.

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the SFY 2016–2017 PIP validation cycle were:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC).*
- *Behavioral Health Hospital Readmissions.*

Amerigroup and **HPN** conducted each required PIP and submitted the required modules to HSAG for validation.

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

[A-3] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

HSAG developed five modules with an accompanying companion guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a core PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Approach to PIP Validation

In SFY 2016–2017, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Modules 4 through 5.

The MCO submitted each module according to the approved timeline. After the initial validation of each module, the MCO received HSAG's feedback and technical assistance and resubmitted the modules for final validation.

The goal of HSAG's PIP validation is to ensure that the DHCFP and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities the MCO conducted during the life of the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirms that any achieve improvement could be clearly linked to the quality improvement strategies implemented by the MCO.

PIP Validation Scoring

HSAG assigned a score of Achieved or Failed for each of the criteria in Modules 4 through 4. Any validation criteria not applicable (N/A) were not scored. Using a standardized scoring methodology,

HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- ***Confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* PIP, HSAG received DHCFP instructions for the MCOs to include all three components in each MCO's SMART Aim statement. HSAG's validation requirements, which were approved by the DHCFP, stipulated that the MCOs must achieve the goal set for each component of the SMART Aim in order for the PIP to receive a rating of *Confidence* or *High Confidence*.

Performance Measure Validation/HEDIS Audit

HSAG performed an audit of the MCOs' HEDIS reporting for their Medicaid and Nevada Check Up programs. Methods and information sources used by HSAG to conduct the audit included:

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.

- Re-abstraction of sample medical records selected by the auditors, with a comparison of results to each MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications related to HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCOs.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors who provided or processed HEDIS 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

In addition, activities conducted prior to on-site meetings with **HPN** and **Amerigroup** representatives included written and email correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of the certified measures approved by NCQA; and a detailed review of a select set of HEDIS measures that the DHCFP requires for reporting.

The IS capabilities assessment consisted of the auditor's findings on IS capabilities, compliance with each IS standard, and any impact on HEDIS reporting. Assessment details included facts on claims and encounter data, enrollment, provider data, medical record review processes, data integration, data control, and measure calculation processes.

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps: First, an audit team review of the medical record review processes employed by the MCOs, including a review of staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data; and second, a reabstraction of selected medical records and a comparison of the audit team's results to abstraction results for medical records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by the DHCFP for Medicaid and Nevada Check Up. The audited measures (and the programs to which they apply) are presented in Table A–1.

Note that the *Weeks of Pregnancy at Time of Enrollment (WOP)* and *Human Papillomavirus Vaccine for Female Adolescents (HPV)* measures were retired for HEDIS 2017; however, HPV was added as a new indicator in the *Immunizations for Adolescents (IMA)* measure.

Table A–1—SFY 2016–2017 Performance Measures for Nevada Medicaid and Nevada Check Up

Performance Measure		Method	Populations	
			Medicaid	Nevada Check Up
1	*Adolescent Well-Care Visits (AWC)*	Hybrid	✓	✓
2	*Ambulatory Care (AMB)*	Admin	✓	✓
3	*Annual Dental Visit (ADV)*	Admin	✓	✓
4	*Childhood Immunization Status—Combos 2–10 (CIS)*	Hybrid	✓	✓
5	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	Admin	✓	✓
6	*Comprehensive Diabetes Care—Excluding <7 indicator (CDC)*	Hybrid	✓	
7	*Follow-Up After Hospitalization for Mental Illness (FUH)*	Admin	✓	✓
8	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity (ADHD) Medication (ADD)*	Admin	✓	✓
9	*Frequency of Ongoing Prenatal Care (FPC)*	Hybrid	✓	
10	*Immunizations for Adolescents (IMA)*	Hybrid	✓	✓
11	*Medication Management for People with Asthma (MMA)*	Admin	✓	✓
12	*Mental Health Utilization (MPT)*	Admin	✓	✓
13	*Prenatal and Postpartum Care (PPC)*	Hybrid	✓	
14	*Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*	Admin	✓	✓
15	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	Hybrid	✓	✓
16	*Well-Child Visits in the First 15 Months of Life (W15)*	Hybrid	✓	✓
17	*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)*	Hybrid	✓	✓

CAHPS Survey

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2017 CAHPS surveys for **HPN** and **Amerigroup**.

The technical method of data collection was through the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with Children with Chronic Conditions [CCC] measurement set) to the child Medicaid and Nevada Check Up populations. **HPN** and **Amerigroup** used a preapproved enhanced mixed-mode methodology for data collection (i.e.,

mailed surveys followed by telephone interviews of nonrespondents to the mailed surveys). Respondents were given the option of completing the survey in Spanish. The survey cover letter provided a telephone number for members to call if they wanted to complete the survey in Spanish.

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as 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).

For each of the five composite scores and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Health Care Guidance Program (HCGP) Performance Measure Validation

In the fall of 2016, HSAG conducted a performance measure validation (PMV) audit of **APH** to verify the accuracy of its reported rates. HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[A-4] developed by CMS as its guide. HSAG's **APH** activity focused on the following objectives:

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jul 18, 2017.

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

HSAG validated a set of performance measures selected by the DHCFP for validation. The measures primarily consisted of performance measures that the DHCFP required contractually but were not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures. In Attachment II of the **APH** contract (RFP/Contract #1958), the DHCFP provided the specifications **APH** was required to use to calculate the performance measures. Table A–2 lists the performance measures that HSAG validated under the scope of this audit. The measurement period for which the PMV was conducted was identified as program period 2 (i.e., June 1, 2015, through May 30, 2016).

Table A–2—Performance Measures for HCGP

Measure ID	Measure Name
CCHU.1	*Ambulatory Care—Sensitive Condition Hospital Admission*
CCHU.2	*Avoidable Emergency Room Visits*
FUP	*Follow-Up With Primary Care Physician After Hospitalization*
MRP	*Medication Reconciliation Post-Discharge*
DEM	*Cognitive Assessment for Dementia*
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
CAP	*Children and Adolescents' Access to Primary Care Practitioners*
W15	*Well-Child Visits in the First 15 Months of Life*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
AWC	*Adolescent Well-Care Visits*
CIS	*Childhood Immunization Status*
PPC	*Prenatal and Postpartum Care*
WOP	*Weeks of Pregnancy at Time of Enrollment*
FPC	*Frequency of Ongoing Prenatal Care*
ABA	*Adult BMI Assessment*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
COL	*Colorectal Cancer Screening*

Pre-audit Strategy

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

HSAG prepared and sent a documentation request letter to **APH**, which outlined the steps in the PMV process. The letter included a request for source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, and a timetable for completion and instructions for submission. The ISCAT was customized to collect information regarding the necessary data that were consistent with the Nevada HCGP and the Nevada Comprehensive Care Waiver (NCCW) special terms and conditions. HSAG responded to ISCAT-related questions received directly from **APH** during the pre-on-site phase.

Upon receiving the completed ISCAT and requested supporting documents, HSAG conducted a desk review of all materials and noted any issues or items that required follow-up. HSAG also conducted an extensive review of **APH**'s source code used to calculate the non-P4P measures. HSAG source code reviewers performed a line-by-line review to assess whether the codes were developed according to the non-P4P measure specifications detailed in **APH**'s contract with the DHCFP. HSAG also checked for any inconsistency in measure interpretation between **APH** and Nevada's actuary (Milliman), the entity responsible for calculating the baseline rates for the non-P4P measures. Findings of the source code review were provided to **APH** before final rates were calculated.

On-site Activities

HSAG conducted the on-site visit with **APH** on September 22–23, 2016. HSAG auditors collected information from **APH** staff members using several methods that included interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities included:

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

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

Post-on-site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from **APH**, including revision of some source code for several measures. **APH** submitted the revised source code

along with revised non-P4P performance measure rates. Upon resolving all outstanding items, HSAG auditors reviewed the revised rates provided by **APH** before issuing the final report.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	94.15%	92.03%	93.83%	94.80%	92.28%	95.17%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	83.55%	83.17%	82.25%	84.29%	81.32%	83.81%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	87.12%	87.04%	86.59%	87.36%	85.54%	87.57%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	83.76%	83.38%	82.95%	85.21%	82.72%	85.51%
Objective 1.2:	Increase well-child visits (0–15 months).	52.78%	55.52%	62.50%	53.77%	56.42%	62.77%
Objective 1.3:	Increase well-child visits (3–6 years).	66.33%	69.09%	68.72%	64.48%	64.75%	65.21%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	64.12%	67.71%†	70.14%	70.32%	73.29%†	71.78%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	54.40%	58.96%†	62.73%	57.91%	62.12%†	62.29%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	43.75%	49.38%†	56.48%	52.07%	56.86%†	59.61%
Objective 1.5:	Increase immunizations for adolescents.	71.93%	74.74%†	79.40%	79.81%	81.83%†	80.78%
Objective 1.6:	Increase annual dental visits for children.	53.21%	51.06%	51.63%	55.03%	56.01%	53.85%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	24.59%	32.13%†	R*	29.68%	36.71%†	R*

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.8:	Increase adolescent well-care visits.	38.43%	47.92%	47.69%	44.04%	43.72%	44.77%
Objective 1.9a:	Increase childhood immunization status (Combination 2).	73.15%	69.58%	72.92%	74.94%	73.72%	73.72%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	66.67%	64.79%	67.13%	70.32%	69.56%	71.05%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	65.28%	62.92%	66.67%	70.07%	69.56%	71.05%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	57.18%	55.21%	56.71%	55.72%	57.74%	61.07%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	32.41%	40.00%	36.11%	38.44%	45.48%	34.79%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	56.48%	53.54%	56.25%	55.72%	57.74%	61.07%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	32.41%	39.79%	36.11%	38.44%	45.48%	34.79%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	29.63%	35.42%	32.18%	31.14%	39.12%	30.41%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	29.63%	35.21%	32.18%	31.14%	39.12%	30.41%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	79.63%	83.71%	81.02%	85.64%	85.76%	82.73%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.76%	41.76%	46.30%	45.74%	40.08%	42.82%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	46.30%	48.84%	45.60%	46.47%	49.42%	48.42%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.09%	59.91%	59.49%	56.93%	60.36%	61.31%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	89.58%	77.65%	90.28%	92.21%	84.46%	90.75%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	55.32%	65.96%	61.11%	60.83%	73.29%	50.36%
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	50.22%	55.20%†	56.19%	46.96%	52.26%†	53.37%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.84%	34.16%†	32.16%	24.14%	31.73%†	32.81%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	53.16%	52.07%	62.50%	57.18%	62.99%	59.12%
Objective 4.2:	Increase timeliness of prenatal care.	75.41%	72.79%	83.33%	73.97%	79.86%	72.75%
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	56.44%	57.10%	62.50%	52.07%	56.21%	60.83%
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	17.80%	14.23%	5.56%	14.60%	15.33%	11.19%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	36.68%	43.01%†	43.51%	46.65%	51.99%†	43.68%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	40.91%	46.82%†	64.91%	58.02%	62.22%†	49.28%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	0.00%	***	3.74%	1.80%	1.62%†	2.26%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge.	*N/A	Complete	Complete	*N/A	Complete	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	52.99%	57.72%	79.81%	56.51%	53.64%	79.16%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	64.55%	66.83%	84.98%	69.41%	70.20%	84.20%

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

Green shading indicates the QISMC goal was met.

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

*** Indicates that QISMC goal could not be established based on prior performance.

*N/A indicates that the PIP had not progressed to the measurement stage at the time of this report.

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

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

R* Indicates that NCQA retired the indicator.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	98.73%	96.25%	98.18%	99.48%	95.23%	98.50%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	89.53%	91.43%	89.45%	89.55%	88.48%	89.61%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.91%	93.36%	91.83%	93.54%	94.45%	92.98%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	88.95%	92.96%	91.08%	90.78%	91.71%	91.29%
Objective 1.2:	Increase well-child visits (0–15 months).	78.05%	73.33%	78.92%	68.00%	64.00%	63.49%
Objective 1.3:	Increase well-child visits (3–6 years).	70.28%	74.17%	76.16%	70.13%	74.76%	67.64%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	62.04%	65.84%†	71.30%	72.02%	74.82%†	73.24%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	55.56%	60.00%†	65.28%	60.34%	64.31%†	61.07%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	47.69%	52.92%†	59.72%	57.18%	61.46%†	58.39%
Objective 1.5:	Increase immunizations for adolescents.	81.61%	83.45%†	83.61%	87.35%	88.62%†	87.59%
Objective 1.6:	Increase annual dental visits for children.	67.05%	68.03%	67.81%	70.11%	72.55%	68.88%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	34.11%	40.70%†	R*	42.62%	48.36%†	R*
Objective 1.8:	Increase adolescent well-care visits.	56.34%	60.83%	60.88%	52.83%	59.92%	54.74%

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.9a:	Increase childhood immunization status (Combination 2).	85.90%	77.10%	91.16%	87.93%	85.11%	84.38%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	78.21%	76.28%	82.87%	84.48%	79.45%	82.14%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	77.56%	76.28%	81.22%	83.91%	78.74%	82.14%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	68.59%	59.10%	72.93%	79.89%	69.53%	71.88%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	46.79%	50.91%	47.51%	52.30%	53.23%	41.52%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	67.95%	59.10%	72.38%	79.31%	68.82%	71.88%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	46.79%	50.91%	47.51%	51.72%	52.52%	41.52%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	42.95%	39.46%	44.75%	50.00%	48.27%	37.50%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	42.95%	39.46%	44.75%	49.43%	47.56%	37.50%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	—	—	—	—	—	—
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	—	—	—	—	—	—
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	—	—	—	—	—	—
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	—	—	—	—	—	—
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	47.76%	52.98%†	58.43%	47.62%	52.86%†	51.02%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.87%	34.18%†	24.72%	26.98%	34.28%†	27.89%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	—	—	—	—	—	—
Objective 4.2:	Increase timeliness of prenatal care.	—	—	—	—	—	—
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	—	—	—	—	—	—
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members with Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	NR	NC	41.67%	39.53%	45.58%†	48.89%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	NR	NC	NR	NR	NC	NR
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	NR	NC	NR	NR	NC	NR
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	Complete	*N/A	*N/A	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	84.85%	86.37%†	82.50%	NR	NC	NR
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	93.94%	94.55%†	97.50%	NR	NC	NR

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

Green shading indicates the QISMC goal was met.

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

*N/A indicates that a rate was not available as the PIP has not progressed to the measurement stage at the time of this report.

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

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

NR indicates that no rate was reported.

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

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

R* Indicates that NCQA retired the indicator.

Attachment D

INTERNAL QUALITY ASSURANCE PROGRAM (IQAP) ON-SITE REVIEW OF COMPLIANCE REPORT

As referenced in Section V, 2.1.4.

State of Nevada

Division of Health Care Financing and Policy

FY2014-15 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance

for

Amerigroup Nevada, Inc.

March 2015

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

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Appendix B. **Corrective Action Plan B-1**

1. Executive Summary

for Amerigroup Nevada, Inc.

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states contract with an external quality review organization (EQRO) to conduct an annual evaluation of their managed care organizations (MCOs) to determine the MCOs' compliance with federal and the State's managed care standards. The Nevada Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group (HSAG) to conduct external quality review (EQR) services for the Nevada Medicaid and Nevada Check Up, Nevada's Child Health Insurance Program (CHIP) managed care program.

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance was to determine **Amerigroup Nevada, Inc.'s** (**Amerigroup**'s) compliance with federal and the State's managed care standards. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **Amerigroup**'s managed care and quality program activities that occurred during FY 2013–2014. HSAG reviewed **Amerigroup**'s compliance with the following:

- State and federal managed care requirements, which were categorized into 14 contract standards, referred to as ***IQAP Standards***
- Outreach and educational materials associated with member rights and responsibilities, member handbook, medical record standards, and the provider manual, referred to as ***Checklists***
- Operational compliance for credentialing, recredentialing, service denial, grievances, and appeal processing activities, referred to as ***File Reviews***

Amerigroup had a composite score of 97.3 percent for all elements evaluated in the FY 2014-2015 IQAP Compliance Review. With a couple of exceptions noted in this report, **Amerigroup** demonstrated strong compliance with the federal and State requirements contained in its managed care contract. Figure 1 summarizes the overall ratings for **Amerigroup**'s IQAP Standards, Checklists, and File Reviews for the FY 2014-2015 IQAP Compliance Review.

Figure 1 presents the combined overall rating for **Amerigroup**.

Figure 1—Overall Rating for Amerigroup	
IQAP Standards Score	For the IQAP Standards, **Amerigroup** received a total score of **98.7%**.
Checklist Score	For the Checklist review, **Amerigroup** received a total score of **100%**.
File Review Score	For the File Review, **Amerigroup** received a total score of **96.5%**.
Overall Score	**Amerigroup** received an overall rating of **97.3%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

2. Background

for **Amerigroup Nevada, Inc.**

Overview

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

According to the 42nd Code of Federal Regulations (CFR) 438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438. To meet this requirement, DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Amerigroup Nevada, Inc.** (**Amerigroup**). According to the federal requirements, the quality of health care delivered to Medicaid recipients enrolled in MCOs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid and Nevada Check Up beneficiaries.

Purpose of the Review

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP)[1-1] On-Site Review of Compliance was to determine **Amerigroup**'s compliance with federal and the State's managed care standards. In addition, HSAG conducted a review of individual files for the areas of credentialing, recredentialing, grievances, appeals, denials, and case management services to evaluate **Amerigroup**'s implementation of the standards. Checklist reviews validated that the managed care organization (MCO) informed members of their rights and responsibilities and other required information in the member handbook. Checklists also confirmed that **Amerigroup** apprised providers of the medical records standards and additional required information in the provider manual. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **Amerigroup**'s quality program activities that occurred during the review period, which was July 1, 2013–June 30, 2014 (i.e., FY 2013–2014).

[1-1] The internal quality assurance program (IQAP) is a strategy consisting of systematic quality improvement activities to ensure an ongoing quality assessment and performance improvement (QAPI) program for services furnished to recipients.

3. Methodology
for **Amerigroup Nevada, Inc.**

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 1988 for Managed Care, and all attachments and amendments in effect during FY 2013–2014. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[1-2] to create the process, tools, and interview questions used for the FY 2014–2015 Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHCFP and the MCOs, as they related to the scope of the review. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the 2-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate its preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases plus an oversample of 5 cases for each of the following file reviews: grievances, appeals, denials, credentialing, recredentialing, and case management.

On-site review activities included**:**

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents HSAG requested that each MCO have available on-site.
- A review of the member cases HSAG requested from each MCO.
- A review of the data systems each MCO used in its operations, which includes but is not limited to care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews conducted with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection (compliance review) tool shown in Appendix A, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the IQAP standards are noted in Table 2 of this report. The results for checklists and file reviews are summarized in Table 3 and Table 4, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created the Corrective Action Plan (CAP) template, shown in Appendix B, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to DHCFP, **Amerigroup** must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **Amerigroup** must submit its CAP to DHCFP **within 21 days of receiving this report.**

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers/subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to: utilization management, quality management, care management and coordination, health management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.
- MCO-maintained files for member grievances and appeals, denials of services, case management, and practitioner credentialing and recredentialing.
- MCO questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCOs' key staff members during the on-site review.

IQAP Standards, Checklists, and Files Reviewed

Table 1 lists the standards reviewed and associated checklists or files reviewed as evidence of compliance with internal policies.

Table 1: IQAP Standards, Checklists, and File Reviews		
IQAP Standard Number	IQAP Standard Name	Number of Elements
I	Internal Quality Assurance Program	54
II	Credentialing and Recredentialing	16
III	Member Rights and Responsibilities	14
IV	Member Information	14
V	Availability and Accessibility of Services	28
VI	Continuity and Coordination of Care	16
VII	Grievances and Appeals	35
VIII	Subcontracts and Delegation	13
IX	Cultural Competency Program	16
X	Coverage and Authorization of Services	23
XI	Provider Dispute and Complaint Resolution	9
XII	Confidentiality and Record Keeping	9
XIII	Provider Information	3
XIV	Enrollment/Disenrollment	11
	Total Number of IQAP Elements	261
Associated IQAP Standard #	Checklist Name	Number of Elements
III	Member Rights and Responsibilities	9
IV	Member Handbook	34
XII	Medical Record Standards	26
XIII	Provider Manual	10
	Total Number of Checklist Elements	79
Associated IQAP Standard #	File Review Name	Number of Elements
II	Initial Credentialing	157
II	Recredentialing	210
VII	Grievances	21
VII	Appeals	42
VII	Denials	30
VI	Case Management	195
	Total Number of File Review Elements	655

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - There was compliance with all documentation requirements, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present and staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any findings of Not Met or Partially Met would result in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the 14 IQAP standards and an overall percentage-of-compliance score across the 14 IQAP standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), and *Not Met* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

Checklists

For the Checklists reviewed, HSAG surveyors scored each applicable element within the checklists as either *Yes*, the element was contained within the associated document, or *No*, the element was not contained within the document. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage

score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, grievances, appeals, denials, and case management to verify that the MCO has put into practice what the MCO documented in its policy. HSAG randomly selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all of the MCO's files. Rather, the file review highlighted when practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO must determine if any areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred.

For the file reviews, HSAG surveyors scored each applicable element within the file review tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

Aggregating the Scores

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

- Documented findings describing the MCOs' performance in complying with each of the IQAP standard requirements.
- Scores assigned to the MCOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the 14 IQAP standards.
- The overall percentage-of-compliance score calculated across the 14 IQAP standards.
- The overall percentage-of-compliance score calculated for each of the file reviews.
- The overall percentage-of-compliance score calculated for each of the checklists.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

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

4. IQAP Findings
for **Amerigroup Nevada, Inc.**

Evaluation Ratings for Amerigroup

From a review of documents, observations, and interviews with key health plan staff, and file reviews conducted during the on-site evaluation, the surveyors assigned **Amerigroup** a score for each element and an aggregate score for each standard. Further, HSAG surveyors scored each element within the checklists and file reviews.

Table 2 presents **Amerigroup**'s scores for the IQAP standards. Details regarding **Amerigroup**'s compliance with the 14 IQAP standards, including the score **Amerigroup** received for each of the elements in each standard, can be found in Appendix A, IQAP FY 2014–2015 Compliance Review Tool for **Amerigroup.**

Table 2—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Internal Quality Assurance Program	**54**	53	52	1	0	1	**99.1%**
II	Credentialing and Recredentialing	**16**	16	15	1	0	0	**96.9%**
III	Member Rights and Responsibilities	**14**	14	14	0	0	0	**100%**
IV	Member Information	**14**	14	14	0	0	0	**100%**
V	Availability and Accessibility of Services	**28**	28	27	1	0	0	**98.2%**
VI	Continuity and Coordination of Care	**16**	16	16	0	0	0	**100%**
VII	Grievances and Appeals	**35**	35	33	1	1	0	**95.7%**
VIII	Subcontracts and Delegation	**13**	13	13	0	0	0	**100%**
IX	Cultural Competency Program	**16**	16	16	0	0	0	**100%**
X	Coverage and Authorization of Services	**23**	23	23	0	0	0	**100%**
XI	Provider Dispute and Complaint Resolution	**9**	9	9	0	0	0	**100%**
XII	Confidentiality and Record Keeping	**9**	9	8	1	0	0	**94.4%**
XIII	Provider Information	**3**	3	3	0	0	0	**100%**
XIV	Enrollment/Disenrollment	**11**	11	11	0	0	0	**100%**
	Total Compliance Score	**261**	**260**	**254**	**5**	**1**	**1**	**98.7%**

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

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

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

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

A review of the IQAP standards show how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Of the 260 applicable elements, **Amerigroup** received a *Met* for

254 elements, a *Partially Met* for 5 elements, and a *Not Met* for 1 element. The findings suggest that **Amerigroup** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate its compliance with the contract. Further, interviews with **Amerigroup** staff showed that staff were knowledgeable about the requirements of the contract and the policies and procedures the MCO employed to meet its contractual requirements.

Table 3 presents the scores for the checklists. HSAG reviewed all requirements related to Member Rights and Responsibilities, Member Handbook, Medical Record Standards, and Provider Manual to verify that each was in compliance with State and federal requirements. HSAG scored the elements required for each of these areas via checklists. Each checklist review area was scored based on the total number of **Amerigroup**'s compliant elements divided by the total number of applicable elements for each of the four areas reviewed.

Table 3—Summary of Scores for the Checklists

Associated IQAP Standard #	Description of File Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
III	Member Rights and Responsibilities	**9**	9	100%
IV	Member Handbook	**34**	34	100%
XII	Medical Record Standards	**26**	26	100%
XIII	Provider Manual	**10**	10	100%
	Checklist Totals	**79**	**79**	**100%**

The results generated by the checklists serve as another indicator of the MCO's ability to develop the required outreach information and ensure that the information contains all contractually required elements. Of the 79 elements reviewed for the checklists, **Amerigroup** received a score of *Met* for all 79 elements. The findings suggest that **Amerigroup** had strong compliance with each of the areas evaluated by the checklists and **Amerigroup** developed the necessary manuals, handbooks, and policies according to contract requirements.

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

Table 4—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Initial Credentialing	**10**	157	156	99.4%
II	Recredentialing	**10**	210	200	95.2%
VII	Grievances	**10**	21	19	90.5%
VII	Appeals	**10**	42	39	92.9%
VII	Denials	**10**	30	30	100%
VI	Case Management	**10**	195	188	96.4%
	File Review Totals	**60**	**655**	**632**	**96.5%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Of the 655 total elements reviewed for the file reviews, **Amerigroup** received a score of *Met* for 632 of the elements. All of the areas reviewed scored greater than 90 percent and four of the six areas reviewed scored greater than 95 percent. These results suggest that **Amerigroup** followed the policies it developed to operationalize the required elements of its contract.

The area with the greatest opportunity for improvement for file review was related to recredentialing where the MCO did not revalidate providers' hospital privileges during recredentialing. For appeals and grievances, the file review results showed that some appeals and grievances were not acknowledged by the corporate office within the required timeframes. Lastly, 6 of the 10 case management files revealed that case managers did not send disease-specific health outreach materials to members in case management or the activity was not documented in the members' case management files.

5. Conclusions and Recommendations *for* Amerigroup Nevada, Inc.

Conclusions and Recommendations

Figure 2 presents overall ratings for **Amerigroup** for IQAP Standards, Checklists, and File Reviews, as well as the overall composite score.

Figure 2—Overall Rating for Amerigroup	
IQAP Standards Score	For the IQAP Standards, **Amerigroup** received a total score of **98.7%**.
Checklist Score	For the Checklist review, **Amerigroup** received a total score of **100%**.
File Review Score	For the File Review, **Amerigroup** received a total score of **96.5%**.
Overall Score	**Amerigroup** received an overall rating of **97.3%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

Amerigroup's overall results for the review of the IQAP standards in the FY 2014–2015 on-site review was 98.7 percent. In addition, **Amerigroup** received a score of 96.5 percent for the file review, a score of 100 percent for the checklist review, and an overall composite score of 97.3 percent. The overall results demonstrated that, with a few exceptions, **Amerigroup** had strong adherence to State and federal standards required by its contract with DHCFP. Amerigroup developed the necessary policies, procedures, and plans to carry out the required functions of the contract and the checklists and file review results demonstrated that **Amerigroup** staff appropriately operationalized the elements described in its policies, procedures, and plans.

Compliance with IQAP Standards

Of the 14 standard areas reviewed, **Amerigroup** achieved 100 percent compliance on 9 standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Member Rights and Responsibilities, Member Information, Continuity and Coordination of Care, Subcontracts and Delegation, Cultural Competency Program, Coverage and Authorization of Services, Provider Dispute and Complaint Resolution, Provider Information, and Enrollment/Disenrollment.

The following standards achieved at least 94 percent or higher for all elements contained in the standards: Internal Quality Assurance Program, Credentialing and Recredentialing, Availability and Accessibility of Services, Grievances and Appeals, and Confidentiality and Record Keeping.

- HSAG recommends that **Amerigroup** prioritizes improvement efforts to address *Partially Met* and *Not Met* elements that were found in the standards that did not achieve 100 percent compliance with all elements. These elements must be addressed in **Amerigroup**'s Corrective Action Plan (Appendix B), which is described in the Corrective Action Plan section of this report.

Compliance with File Review

Amerigroup achieved 99.4 percent compliance on the initial credentialing file review and a 95.2 percent compliance on the recredentialing file review, which indicates the MCO's overall compliance with the credentialing and recredentialing file review standards. For recredentialing, the DHCFP contract requires MCOs to verify hospital privileges during the recredentialing process. **Amerigroup** staff stated that they followed NCQA guidelines, which did not require verification of hospital privileges; therefore, it was noted that this step in the recredentialing process did not occur.

- HSAG recommends that **Amerigroup** review the recredentialing requirements of the contract and include a process for verifying hospital privileges during recredentialing.

Amerigroup received 100 percent compliance for all required elements related to the file review for service Denials. All files reviewed demonstrated **Amerigroup**'s compliance with the standards related to notices of decision when the MCO denied a service. **Amerigroup** received a 90.5 percent for Grievance file review and a 92.9 percent for the Appeal file review. For both the Grievance and Appeal file reviews, the files showed that **Amerigroup** did not acknowledge receipt of grievances or appeals within the required timeframes for all cases. The Appeals file review showed that 3 of 10 appeals were acknowledged outside of the MCO's specified timeframe for acknowledging appeals, which was within five calendar days. The grievance file review showed that 2 of 10 grievances were acknowledged outside of the required timeframes, which was within five calendar days.

- HSAG recommends that **Amerigroup** work with its corporate office to ensure that grievances and appeals received by its corporate office are acknowledged within the timeframes stipulated by the MCO's policies.

Amerigroup achieved 96.5 percent compliance on the case management file review. **Amerigroup** had strong adherence to the contractual requirements for identification and performing and documenting a comprehensive assessment. In one file, the assessment was performed outside of the timeframe. All of the files reviewed showed that **Amerigroup** had developed and documented a comprehensive case management plan, but in six of the files reviewed, there was no evidence that disease-specific health education materials were sent to the member. **Amerigroup** staff speculated that the materials were sent, but it was not documented in the case management file. **Amerigroup** met all of the requirements evaluated for reassessment of the care management plan. Further, the **Amerigroup** case management files showed that **Amerigroup** case managers evaluated members' barriers to achieve members' goals and worked with members to overcome those barriers.

- HSAG recommends that **Amerigroup** complete comprehensive assessments of members within 90 days of enrollment.
- HSAG recommends that **Amerigroup** case managers send health education and disease-specific information to members in case management and document the activity in the member's case management record.

Compliance with Checklists

Amerigroup achieved 100 percent compliance for the checklist review, which demonstrates high compliance with the requirements for information included in the member rights and responsibilities, the member handbook, medical record standards, and the provider manual.

6. Corrective Action Plan
for **Amerigroup Nevada, Inc.**

Corrective Action Plan

Appendix B contains the Corrective Action Plan (CAP) template HSAG prepared for **Amerigroup** to use in preparing its CAP to be submitted to DHCFP. The template lists each of the elements for which HSAG assigned a score of *Partially Met* or *Not Met*, and the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **Amerigroup** must use this template to submit its corrective action plan to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **Amerigroup**'s CAP must be submitted to DHCFP **no later than 21 calendar days after receipt of this report**.

The following criteria will be used to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any corrective action plans that do not meet the above criteria will require resubmission by the organization until approved by DHCFP. Implementation of the CAP may begin once approval is received. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **Amerigroup** in its submitted CAP.

Attachment E

COMPLIANCE REVIEW REPORT OF CMO

As referenced in Section V, 2.1.5.2.

State of Nevada

Division of Health Care Financing and Policy

FY 2014-2015 Compliance Review
of
McKesson Technologies, Inc.

March 2015

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

FY 2014-2015 Compliance Review Summary
for **McKesson Technologies, Inc.**

Executive Summary

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

The DHCFP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc.** (**McKesson**), to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. DHCFP requested its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct an interim assessment of McKesson's compliance with its contract six months after **McKesson**'s CMO operations began in June 2014. The purpose of the fiscal year (FY) 2014-2015 Compliance Review was to verify that **McKesson** had operationalized key elements of the program once services commenced. HSAG conducted an on-site compliance review of **McKesson**'s HCGP on December 10–11, 2014.

HSAG performed the compliance review in two-phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation. Phase II of the compliance review consisted of a two-day on-site review, which occurred on December 10–11, 2014 in the **McKesson** Carson City, Nevada office.

Two months prior to the on-site review, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files used for the desk review and on-site review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review, which included:

- **Questionnaire** – used to collect additional information about **McKesson**'s operational structure, number and type of staff designated to the Nevada HCGP, and enrollment counts by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1 – October 31, 2014)
- **Completed compliance review standards tool** – wherein **McKesson** listed all of the documents and information it offered as evidence of compliance with each element for each of the 12 standards reviewed
- **Care management data file** – using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plans were developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014

- **Grievance data file** – using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014

For the purposes of this report, HSAG uses the following definitions:

- **Enrolled person** – a person who meets the eligibility criteria for the program and has been identified through **McKesson**'s risk stratification process as someone who would benefit from the HCGP
- **Served person** – a person who meets the eligibility criteria, is enrolled in the HCGP, and has completed a health risk assessment and care management plan with a **McKesson** care manager

McKesson's completed Questionnaire showed that 39,543 persons were enrolled in the program as of October 31, 2014. The care management file submitted by **McKesson** showed that of the 39,543 persons enrolled in the program, **McKesson** completed an assessment and a care management plan for 1,828 persons, or 4.6 percent of the enrolled population. Of the 1,828 persons served, **McKesson** stratified enrollees into the following care management categories: 83 persons in complex care (4.5 percent), 451 in the high category (24.7 percent), 738 in the moderate category (40.4 percent), and 556 in the low category (30.4 percent).

The on-site compliance review included a review of 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Some of the elements contained in each standard were part of the readiness review; however, most the elements contained in the standards could not be assessed prior to the program start date, which is why they were included in the compliance review. Table 1 below lists each of the standards reviewed.

Table 1—Compliance Review Standards

Standard	Standard Name
I	Stratification of Enrollees
II	Care Management Teams
III	Care Planning
IV	Mental Health Care Management Services
V	Health Education Materials
VI	Nurse Triage and Call Services
VII	Emergency Department Redirection
VIII	Stakeholder Outreach and Education
IX	Feedback to PCPs
X	Provider Services
XI	Care Transitions
XII	Operational Structure and Reporting

Overall, **McKesson** received a composite score of 84.6 percent. Of the 12 standards reviewed, **McKesson** met all of the elements for the following 5 standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education. **McKesson** received a ***Partially Met*** for one

or more elements contained in 7 of the 12 standards reviewed, which included: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to Primary Care Providers (PCPs), Provider Services, Care Transitions, and Operational Structure and Reporting.

Since care management activities have the potential to positively impact the quality of services as well as health outcomes, enrollees benefit from early identification, enrollment, assessment, and receipt of care management services. HSAG used the care management data file submitted by **McKesson** to calculate the average length of time between the date of enrollment in the program and the date an assessment was performed. During the on-site review, HSAG reviewers discussed with **McKesson** staff the length of time between the date a person was enrolled in the program and the date care needs were assessed. On average, there were 72 days between the date of enrollment and the date of assessment by **McKesson** care managers.

In the case of pregnant enrollees, the pregnancy is time-limited so the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the date the pregnant woman was enrolled in the program and the date her needs were assessed. In one of the 20 files reviewed, HSAG reviewers found that the woman was assessed 154 days after being identified and enrolled in the program and she had already given birth by the date of her assessment.

During both the Readiness Review and the Compliance Review, HSAG found the quality of staff proposed for the program to be consistent with contractual requirements. Further, HSAG found that **McKesson** maintained appropriate written descriptions for developing and operating multidisciplinary care management teams. The quantity of staff designated to the program, however, was inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program (39,543). Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

HSAG used the care management enrollment file to select 20 cases to be included in the care management file review. When reviewing care management files, HSAG reviewers noted that **McKesson** documented most of the elements required by its contract with DHCFP. After **McKesson** completed the initial assessment and care management plan, **McKesson's** electronic care management system, VITAL, generated a copy of the care management plan and faxed it to the PCP, in most cases. The elements related to ongoing care management required the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. **McKesson** documented its communication with the enrollee. Although **McKesson** documented an enrollee's noncompliance with the care management plan and **McKesson**'s inability to reach the enrollee after an assessment was performed, the documentation, in many instances, did not show that either concern was communicated to the enrollee's PCP.

HSAG used the grievance file submitted by **McKesson** to select 10 cases to be included in the grievance file review. The results of the grievance file review showed that **McKesson** staff verbally acknowledged receipt of the grievance during the initial call from the enrollee, and staff members with appropriate expertise handled the grievances. HSAG reviewers found that all notes concerning

the investigation and resolution of the grievances were not documented in the grievance files, and many times the grievance file did not contain the date the grievance was resolved.

The complete findings of the compliance review and associated recommendations are contained within the sections that follow and Attachments to this report. To remedy any deficiencies, **McKesson** must submit a corrective action plan (CAP) to the DHCFP **within 21 days of receiving this report**. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **McKesson** in its submitted CAP.

Background

On April 24, 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) submitted to the Centers for Medicare and Medicaid Services (CMS) a Medicaid section 1115 Research and Demonstration proposal entitled the Nevada Comprehensive Care Waiver (NCCW). The NCCW program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system and assist the DHCFP in reaching its goal to expand enrollment of a target population into a managed Fee-for-Service (FFS) system.

In February 2012, the DHCFP issued a Request for Proposal (RFP) to contract with a vendor (herein referred to as the "Care Management Organization" or "CMO") to administer care management services to NCCW program enrollees. The NCCW program mandates care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations (MCOs). The CMO supports improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the CMO is mandatory for demonstration-eligible, fee-for-service Medicaid beneficiaries with qualifying health conditions. Enrollment in the CMO is optional for the qualifying American Indian/Alaska Native (AI/AN) population. Children's Health Insurance Program (Nevada Check Up) recipients also are excluded from the CMO.

After conducting an evaluation of all proposals, the DHCFP awarded a contract to **McKesson Health Solutions**, which later was changed its name to **McKesson Technologies, Inc.** (**McKesson**). The contract took effect November 12, 2013. **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014.

Operational Readiness and Compliance Reviews

There are a number of core functions, roles, activities, and responsibilities that are integral to the success of a care management program. To assess the operational readiness of the CMO, DHCFP requested its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct a readiness review of the CMO prior to the CMO enrolling individuals. The purpose of the readiness review was to verify that the CMO had an appropriate operational structure to oversee the coordination of Medicaid services to program participants and meet the structural, operational, and administrative requirements of the contract. HSAG conducted the readiness review in March 2014 and provided feedback to the DHCFP and **McKesson** regarding the types of corrections that were to be made in order to satisfy all requirements of the readiness review. **McKesson** was required to work with DHCFP staff to remediate any areas of concern that were discovered during the readiness review. At the time of the FY 2015 Compliance Review, there were several items that remained outstanding from the FY 2014 Readiness Review that had not been remedied by **McKesson.**

DHCFP requested that HSAG conduct an interim assessment of **McKesson**'s compliance with its contract within six months of **McKesson**'s program start date in June 2014. HSAG conducted a compliance review of **McKesson**'s HCGP December 10–11, 2014. The purpose of the FY 2014–

2015 Compliance Review was to verify that **McKesson** had operationalized key elements of the program once services commenced on June 1, 2014. The FY 2014–2015 Compliance Review enabled HSAG to review elements that could not be reviewed during the March 2014 readiness review because the program had not yet begun. The period of time under review (review period) was June 1, 2014 through October 31, 2014.

Methodology for Conducting the Compliance Review

HSAG performed the FY 2015 Compliance Review in two-phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation and information supplied by **McKesson**. Phase II of the compliance review consisted of a two-day on-site review, which occurred December 10–11, 2014 in the **McKesson** Carson City, Nevada office.

On October 8, 2014, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files so HSAG may prepare for the review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review. **McKesson** uploaded the following information to HSAG's secure FTP site by November 7, 2014, which was the required due date:

- **Questionnaire** – used to collect additional information about **McKesson**'s operational structure, number and type of staff designated to the Nevada HCGP, and counts of persons enrolled in the program by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1 – October 31, 2014)
- **Completed compliance review standards tool** – wherein **McKesson** listed the all of the documents it offered as evidence of compliance with each element for each standard
- **Care management data file** – using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plan was developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014
- **Grievance data file** – using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014

Phase I Review Tools and Activities

Phase I consisted of a desk-review of **McKesson**'s completed Questionnaire, policies and procedures, reports, guidelines, and other documentation that demonstrated compliance with contractual elements within the Compliance Review Standards tool. The completed Questionnaire allowed HSAG to obtain additional information about **McKesson** and its operational structure. The Questionnaire was not scored.

Review of Compliance with Standards

The **Compliance Review Standards tool** (Attachment A) included 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Table 2, on the following page, lists each of the standards contained in the Compliance Review Standards tool.

Table 2—Compliance Review Standards	
Standard	Standard Name
I	Stratification of Enrollees
II	Care Management Teams
III	Care Planning
IV	Mental Health Care Management Services
V	Health Education Materials
VI	Nurse Triage and Call Services
VII	Emergency Department Redirection
VIII	Stakeholder Outreach and Education
IX	Feedback to PCPs
X	Provider Services
XI	Care Transitions
XII	Operational Structure and Reporting

HSAG used the Compliance Review Standards tool (Attachment A) to record the findings from the review of **McKesson** documentation and interviews with key staff during the on-site review. Within the review tool, **McKesson** completed the column labeled, *Information Submitted as Evidence by McKesson*, to include all of the documents listed as evidence of compliance for each element. **McKesson** was encouraged to list and submit to HSAG any policies, procedures, reports, monitoring tools, screen prints, copies of emails, or other documentation that provided evidence of the CMO's compliance with the contractually mandated elements. On November 7, 2014, **McKesson** uploaded the completed tool and associated documentation to HSAG's secure FTP site and organized the documents in subfolders labeled according to the corresponding standard.

From the documentation submitted by **McKesson** and interviews conducted with key staff during the on-site review, HSAG scored each element within the Compliance Review Standards tool as either, *Met*, *Partially Met*, or *Not Met*. Any element that was not applicable to **McKesson** at the time of the review was scored as *N/A*, or *Not Applicable*. A composite score was calculated by summing the total possible points and dividing it by the total items scored as *Met* (1.0 point), *Partially Met* (0.5 point), or *Not Met* (0 points).

Care Management Enrollment Statistics

Since care management activities have the potential to positively impact the quality of services as well as health outcomes, enrollees benefit from early identification, enrollment, assessment, and receipt of care management services. HSAG reviewed care management enrollment statistics from a care management file submitted by **McKesson**. From the file, HSAG calculated the total number of days between the date of enrollment into care management and the date the assessment and care management plan were completed for each enrollee. HSAG then averaged the total number of days between the enrollment date and assessment date for all enrollees. HSAG also calculated the average number of days from the enrollment date to the assessment date for enrollees who were pregnant at the time of enrollment.

Care Management Staffing

The number and type of staff designated to a care management program are important to the success of a care management program. Well-trained and qualified staff can assist persons with chronic conditions manage their illnesses and appropriately navigate the healthcare system. Care manager-to-enrollee ratios by risk level help to verify that there are enough care managers to provide care management services to program enrollees. Within its Questionnaire, **McKesson** submitted an organizational chart and a list of the number and type of full-time equivalent (FTE) staffs dedicated to the Nevada HCGP. HSAG reviewed number and type of care management staff dedicated to the Nevada HCGP, who also had direct contact with enrollees during the review period. HSAG calculated the total number of **McKesson** and ValueOptions FTEs that had direct contact with enrollees. ValueOptions serves as a subcontractor to **McKesson** and provides mental health case management services to HCGP enrollees under the direction of **McKesson**.

Checklists

HSAG reviewers also scored each element within **Checklists** that corresponded to two standards within the Compliance Review Standards Tool. The corresponding **Checklists** were:

- **Checklist 1: Transitioning Recipients into Care Management** (Attachment B-1), the information collected using this checklist was recorded in Element 1 of Standard XI: Care Transitions, in the Compliance Review Standards tool.
- **Checklist 2: Required Reports** (Attachment B-2), the information collected using this checklist was recorded in Element 2 of Standard XII: Operational Structure and Reporting, in the Compliance Review Standards tool.

HSAG surveyors used the Checklist to document findings of key elements in the contract related to transitions of care and required reports. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the CMO were scored as *N/A* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements receiving a *Yes* score and divided it by the total number of applicable elements.

Phase II Review Tools and Activities

Phase II of the review consisted of a two-day on-site review at **McKesson**'s Carson City, Nevada office. During the on-site review, HSAG interviewed key staff to inquire about several items that were incomplete from the desk review of documentation. **McKesson** staff members were given the opportunity to provide additional documentation until the end of the second day of the on-site review to provide evidence of its compliance with a given element. HSAG surveyors assessed the additional information provided by **McKesson** staff and documented the findings in the Compliance Review Standards tool.

While on-site, HSAG reviewers assessed **McKesson**'s application of contractually required care management activities—identification, risk stratification, comprehensive assessments, care plan

development, ongoing care management services, hospital discharge and care transitions, and care monitoring and reassessment—through a review of 20 enrollee care management records. The on-site review also consisted of a review of 10 enrollee grievances and **McKesson**'s processing of each grievance filed.

Care Management File Review

To obtain the list of enrollee records to be included in the review, **McKesson** provided a list of all enrollees in the HCGP who were currently receiving or had received care management services during the review period (June 1, 2014 through October 31, 2014). **McKesson** uploaded the complete list to HSAG on November 7, 2014 using the data file layout specified by HSAG. From the uploaded file, HSAG generated a list of 20 sample cases, plus an oversample of 7 cases, and posted them to the HSAG secure FTP site for **McKesson** to retrieve five business days prior to the on-site review. While on-site, HSAG reviewed all 20 sample cases.

The care management file review tool was organized into five sections. The evaluation elements within each section were required by **McKesson**'s contract with the DHCFP. The five sections were:

- Section I: Enrollee Identification and Risk Stratification
- Section II: Enrollee Assessment
  - Primary care provider (PCP) selection
  - Linking members to community resources
- Section III: Care Plan Development
- Section IV: Ongoing Care Management
  - Care transitions
  - Hospital discharge planning
- Section V: Care Monitoring and Reassessment

Using the **Care Management File Review Tool** (Attachment C), HSAG scored each element as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A*, and were not included in the denominator of the total score. Elements in Section I were used to collect information about the enrollee and were not scored. For Sections II, III, IV, and V, HSAG surveyors added the number of elements receiving a *Yes* score for the respective Section and divided it by the total number of applicable elements for the same Section.

Grievance File Review

HSAG surveyors also reviewed grievance records during the on-site review. On November 7, 2014, **McKesson** staff uploaded a grievance data file to HSAG's secure FTP site using a data file layout specified by HSAG. HSAG surveyors used the **Grievance File Review Tool** (Attachment D) tool to document findings from a review of **McKesson**'s grievance records. From data provided by **McKesson**, HSAG selected 10 grievance records to review. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*,

the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A*, and were not included in the denominator of the total score. For each component reviewed, HSAG added the number of elements receiving a *Yes* score for the respective component and divided it by the total number of applicable elements for the same component.

Compliance Review Findings

Phase I – Results for Compliance with Standards

Table 3 displays the compliance review results. A total percentage score was calculated by summing the total possible points and dividing it by the total items scored as *Met* (1.0 point), *Partially Met* (0.5 point), or *Not Met* (0 points). Elements that were *N/A* were not included in the denominator of the score.

Table 3—Summary of Results of Compliance with Standards

Standard Number	Standard Name	Total Elements	Applicable Elements	Met	Partially Met	Not Met	N/A
I	Stratification of Enrollees	3	3	2	1	0	0
II	Care Management Teams	2	2	2	0	0	0
III	Care Planning	2	2	1	1	0	0
IV	Mental Health Care Management Services	2	2	2	0	0	0
V	Health Education Materials	1	1	1	0	0	0
VI	Nurse Triage and Call Services	4	4	2	2	0	0
VII	Emergency Department Redirection	3	3	3	0	0	0
VIII	Stakeholder Outreach and Education	2	2	2	0	0	0
IX	Feedback to Primary Care Providers (PCPs)	2	2	1	1	0	0
X	Provider Services	3	2	1	1	0	1
XI	Care Transitions	1	1	0	1	0	0
XII	Operational Structure and Reporting	2	2	1	1	0	0
	Total Elements	**27**	**26**	**18**	**8**	**0**	**1**
	Composite Score	**22/26 84.6%**					

Overall, **McKesson** received a composite score of 84.6 percent. The findings suggest that **McKesson** met most of the required elements evaluated as part of the compliance review. None of the elements were scored *Not Met* and eight elements were scored *Partially Met*.

Of the 12 standards reviewed, **McKesson** met all of the elements for the following standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education.

The following standards were identified as opportunities for improvement since **McKesson** received a ***Partially Met*** for one or more elements contained in the standards: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to Primary Care Providers, Provider Services, Care Transitions, and Operational Structure and Reporting. Examples of the areas identified for improvement include, but are not limited to:

- **Face-to-face interactions with enrollees** – **McKesson**'s policy listed the percentage of enrollees that receive a face-to-face contact by stratification of risk: 25 percent of the complex-risk enrollees, 20 percent of the high-risk enrollees, and 15 percent of the moderate-risk

enrollees to receive a face-to-face contact. Documents submitted by **McKesson** indicated that very few face-to-face interventions had been accomplished prior to the on-site review December 10, 2014; therefore, **McKesson** was not in compliance with its own policy.

- **Nurse triage and nurse advice call service lines** – The contract requires that 90 percent of telephone calls are answered within five rings during live voice answering times. **McKesson** submitted reports from June 2014–October 2014 with summary results for telephone calls received during each month. The reports did not list the calls answered within five rings, so the information concerning calls handled within 30 seconds was used for that requirement. **McKesson** met the 90 percent requirement in June and July, but failed to meet the standard in August (80 percent), September (85 percent), and October (88 percent).
- **Nurse triage and nurse advice call service lines** – The contract requires that 90 percent of calls are answered by a live operator in less than two minutes. None of the **McKesson** reports submitted for review contained the information concerning the calls answered by a live operator in less than two minutes.
- **Feedback to PCPs** – The contract requires the CMO to provide feedback on gaps between recommended care and actual care received by the Enrollees attributed to an identified PCP. The case management file review provided evidence that, in many instances, PCPs were notified of gaps of care for enrollees who were empaneled with the PCP; however, there were some cases where the PCP was not notified of the barriers or gaps in care.
- **DHCFP approval of required documents** – There were two documents (Provider Education Plan and Transitioning Beneficiaries Guideline) that required DHCFP approval that had not been approved by the DHCFP. At the time of the on-site review, **McKesson** staff revised the documents to be in compliance with contractual requirements, but had not yet submitted the revised documents to the DHCFP for approval.
- **Monitoring and Reporting** – The contract requires several reports to be developed and used for monthly, quarterly, and annual monitoring. The required reports must be submitted to the DHCFP by the required schedule. Some of the reports met the elements required by the contract. The following reports, however, did not contain all of the contractually required elements: Enrollee Stratification Report, Enrollee Contact Report, Call Center and Nurse Triage Report, Disenrollment Report, Noncompliance Report, Provider Profiling Report, and Grievance, Complaint, and Dispute Resolution Report.

The complete findings that detail the specific elements that were scored *Partially Met*, and their associated recommendations, are found in Attachment A.

Phase I – Care Management Enrollment Statistics

Table 4 shows, by risk category, the number of Medicaid recipients enrolled in the program, the number of persons served (i.e., assessment completed) in the program, the percent of the total enrolled who were served in the program, and the average number of days between date of enrollment and the date the assessment was completed. Risk categories were defined by **McKesson** as Complex (most comprehensive and complex care needs), High (high care needs), Moderate (moderate care needs), and Low (low care needs).

Table 4—Persons Enrolled and Served in the HCGP				
Categories	Number of Persons Enrolled	Number of Persons Served	Percent of Total Enrolled Who were Served	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	314	83	0.2%	57 days
High (3)	2,282	451	1.1%	69 days
Moderate (2)	4,696	738	1.9%	81 days
Low (1)	32,251	556	1.4%	65 days
Total	**39,543**	**1,828**	**4.6%**	**Average 72 days**

Of the 39,543 persons enrolled in the program, 1,828 (4.6 percent) enrollees were served, where an assessment and care management plan were developed. On average, 72 days passed between the enrollment date and the date the enrollee was assessed by **McKesson** care managers. Persons served in the moderate risk level had assessments completed, on average, 81 days after enrollment in the program. Persons with complex care needs were assessed, on average, more quickly than that of the other risk categories at 57 days between the date of enrollment and the date of assessment.

Table 5 shows the number of enrollees who had an assessment completed within 0–30 days, 31–60 days, 61–90 days, or greater than 90 days after the person was enrolled in the HCGP.

Table 5—Number of Days Between Enrollment and Assessment		
Assessment Completed with X-X Days of Enrollment	Number of Enrollees	Percent of Total Enrollees
0–30 days	427	23%
31–60 days	447	24%
61–90 days	265	14%
Greater than 90 days	689	38%
Total	**1,828**	**100%**

Table 5 shows that less than half of all enrollees had an assessment completed within 60 days, and 38 percent of enrollees had an assessment completed 90 or more days after the being enrolled in the program.

Table 6 on the following page shows the enrollment statistics for pregnant women in each risk category. Table 6 also shows the average number of days between the date of enrollment and the date the assessment was completed.

Table 6—Enrollment for Pregnant Women		
Categories	Number of Pregnant Enrollees	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	0	N/A
High (3)	13	72 days
Moderate (2)	10	68 days
Low (1)	25	52 days
Total	**48**	**Average 61 days**

As of October 31, 2014, there were a total of 48 pregnant women who had received care management services in the HCGP. Table 6 shows, on average, 61 days passed before a pregnant enrollee was assessed by a **McKesson** care manager. Pregnant enrollees with the highest acuity level (High Risk) were assessed, on average, 72 days after being enrolled in the program. There were multiple instances where more than 110 days lapsed between the enrollment date and assessment date. There was one notable instance where 154 days had passed between the date of enrollment and the date of assessment, and the enrollee already gave birth by the time her care management needs were assessed.

Phase I – McKesson Care Management Staffing Review

Table 7 shows the numbers and types of staff **McKesson** identified for the HCGP that had direct contact with enrollees during the review period. Any positions that were unfilled at the time of the on-site review are noted as "vacant."

Table 7—HCGP Staffing for Staff Working Directly with Enrollees	
McKesson Staff Title	Full-Time Equivalent (FTE) Count
Case Manager	3.0
Care Manager	8.1
Social Worker	2.0
Triage Health Resource Coordinator	As needed based on call volume (Up to 0.03 FTE used for Nevada)
Triage Nurse	As needed based on call volume (Up to 0.5 FTE used for Nevada)
Community Health Worker	2.0
McKesson Total	**15.1**
ValueOptions Staff Title	Full-Time Equivalent (FTE) Count
Case Manager-Mental Health (MH)	1.0
Care Manager-MH	3.0 + 2.0 Vacant
Community Health Worker	2.0 + 1.0 Vacant
Pharmacist	As needed
ValueOptions Total	**6.0 + 3.0 Vacant**
HCGP Total	**21.1 + 3.0 Vacant** **24.1 Total FTEs**

For the HCGP, **McKesson**'s Questionnaire noted that there were 15.1 full-time equivalents (FTEs) for **McKesson** and 9.0 FTEs for ValueOptions. Of the 9.0 total FTEs for ValueOptions, 3 FTE positions were unfilled at the time of the review. Overall, there were 24.1 FTEs designated to the Nevada HCGP.

According to the case management risk stratification levels provided by **McKesson**, 3 percent of the population is considered complex risk, 7 percent of the population is considered high risk, 20 percent of the population is considered moderate risk, and 70 percent of the population is considered low risk. Table 8 shows the stratification of the population using **McKesson**'s case management risk stratification levels for the 39,543 people enrolled in the program at the time of the review. In addition, the table shows the case manager-to-enrollee ratios proposed by **McKesson** for each risk level. For complex risk enrollees, **McKesson** proposed one case manager to 75 enrollees; for high risk, one case manager to 186 enrollees; for moderate risk, one case manager to 244 enrollees; and any available case manager for enrollees in the low risk category. The table also shows the number of case managers anticipated to be needed in order to satisfy the care manger-to-enrollee ratios proposed by **McKesson**. Lastly, the table shows the surplus or deficit of care managers based on number and types of FTEs submitted by **McKesson** in its Questionnaire. A deficit is noted in red text.

Table 8—Number of Care Managers to Maintain Ratios

Case Management (CM) Risk Level	Percent of Population	Max. Number of Members Served by CM Risk Level	Ratio 1 CM to: XX Enrollees	Number of Care Managers to Maintain CM Ratio	Surplus/Deficit of FTEs to Fulfill Ratios
Complex (4)	3%	1,186	75	15.82	**39.01 FTEs**
High Risk (3)	7%	2,768	186	14.88	
Moderate Risk (2)	20%	7,909	244	32.41	
Low Risk (1)	70%	27,680	Low risk Enrollees may interact with any available care manager.	Unknown	
Total	**100%**	**39,543**		**63.11**	

*Note: 63.11 Care Managers (CMs) represents the minimum number of CMs needed to serve 39,543 members based on McKesson's proposed risk stratification and care manager-to-enrollee ratios.

The risk stratification levels and case manager-to-enrollee ratios proposed by **McKesson** suggest that the anticipated number of staff needed to effectively care manage the population was 63.11 FTEs. As shown in Table 7, **McKesson** has designated 24.1 FTEs to have direct contact with enrollees and provide care management services to enrollees of the Nevada HCGP. Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

As shown in Table 3, **McKesson** met the contractual requirements reviewed in Standard II: Care Management Teams. The elements for this standard focused on the written descriptions **McKesson** maintained for developing and operating multidisciplinary care management teams and the supervision of those teams. The quality of the types of staff used to operate the care teams was found to be sufficient in both the Readiness Review and the Compliance Review. The quantity of

staff designated to the program, however, is inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program. This discrepancy was noted in the Readiness Review findings and no evidence was found to indicate that this discrepancy has been remedied.

Phase I – Checklist Results

Table 9 details the findings from the Checklists. To obtain a percentage score for the Checklists, HSAG added the total number of elements receiving a *Yes* score and divided it by the total number of applicable elements.

Table 9—Summary of Results of Checklists

Checklist Number	Checklist Name	Elements	Yes	No	N/A	Percent Compliant
I	Transitioning Recipients into Care Management	12	12	0	0	**12/12 100%**
II	Required Reports	13	5	7	1	**5/12 41.7%**

McKesson scored 100 percent for all elements contained in Checklist I: Transitioning Recipients into Care Management.

For Checklist II: Required Reports, **McKesson** scored 41.7 percent. As shown in Table 3 and detailed in the findings for Standard XII: Operational Structure and Reporting in Attachment A, **McKesson** did not meet most the required elements in Checklist II: Required Reports. In some cases, the same opportunities for improvement were noted in the Readiness Review findings and had not been remedied by at the time of the on-site compliance review. **McKesson** staff were encouraged to review the remediation plan **McKesson** submitted on April 10, 2014 to become familiar with the strategies **McKesson** identified to correct the issues identified during the readiness review. Detailed findings of the Transitioning Recipients into Care Management and Required Reports Checklists may be found in Attachments B-1 and B-2, respectively.

Phase II – Results of Care Management File Review

Table 10 on the following page shows the results of the care management file review. Section I of the care management file review tool contained demographic information and was not scored. Sections II—V of the care management file review were scored. HSAG surveyors added the number of elements receiving a *Yes* score for the respective Section and divided it by the total number of applicable elements for the same Section.

Table 10—Results of Care Management File Review				
Elements	Section II: Enrollee Assessment	Section III: Care Plan Development	Section IV: Ongoing Care Management	Section V: Care Monitoring and Reassessment
Total Number of Elements	440	240	320	60
Total Number of Elements N/A	14	44	176	50
Total Number of Applicable Elements	**426**	**196**	**144**	**10**
Total Elements Contained in File (Yes)	420	171	114	10
Total Elements Not Contained in File (No)	6	25	30	0
Percent of Elements Contained in File	**420/426 98.69%**	**171/196 87.2%**	**114/144 79.2%**	**10/10 100%**

When reviewing care management files, HSAG reviewers noted that **McKesson** documented most of the elements required by its contract with DHCFP. **McKesson** scored a 98.6 percent for Section II: Enrollee Assessment and 87.2 percent for Section III: Care Plan Development. The elements in Section III that were not well documented in the CMO files were related to enrollee goal-setting and tracking the progress toward enrollee goals.

The section of care management requirements that proved to be the most challenging for **McKesson** was Section IV: Ongoing Care Management, which received a score of 79.2 percent. The standards in this section required the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. The care management files showed that communication between **McKesson** staff and enrollees was documented in the enrollees' files. After **McKesson** completed the initial assessment and care management plan, the VITAL system generated a copy of the care management plan and faxed it to the PCP, in most cases. In many cases, however, additional follow-up with the PCP concerning an enrollee's noncompliance with the care plan or **McKesson**'s inability to reach the enrollee was not documented.

Many of the elements in Section IV were not applicable at the time of the review because the elements focused on discharge planning and follow-up after an enrollee was discharged from the hospital. Only two enrollees were hospitalized during the period being reviewed. For Section V: Care Monitoring and Reassessment, many of the enrollees had not been enrolled in care management long enough to warrant a reassessment (within 6 months of the date of the initial assessment); therefore, many of these elements were not applicable at the time the on-site review occurred. **McKesson** scored 100 percent on the 10 elements that were applicable in Section V.

Phase II – Results of Grievance File Review

Table 11 on the following page shows the results of the grievance file review. HSAG reviewed a total of 10 grievance files. For each component reviewed, HSAG added the number of elements receiving a *Yes* score for the respective component and divided it by the total number of applicable elements for the same component.

Table 11—Results of Grievance File Review				
Grievance Elements	Provider Obtained Permission to File on Enrollee Behalf	Grievance Acknowledged	Resolved within 30 Days	Appropriate Level of Expertise
Total Number of Elements	10	10	10	10
Number of Applicable Elements	0	10	10	10
Number of Compliant Elements	N/A	10	4	10
Percent Compliant	**N/A**	**10/10 100%**	**4/10 40%**	**10/10 100%**

The results from the grievance file review indicated that **McKesson** staff verbally acknowledged receipt of the grievance during the initial call from the enrollee, and staff members with appropriate expertise handled the grievances. None of the grievances were file by a provider on behalf of an enrollee. All ten files contained the date the grievance was received, but the process undertaken to resolve the grievance was not found in many of the files. Overall the results of the grievance file review showed that all notes concerning the investigation and resolution of the grievances were not documented in the grievance files. **McKesson** did not always notify enrollees of the resolution of the grievance and record the final date of closure in the grievance files.

Conclusions and Recommendations

McKesson received a composite score of 84.6 percent. Of the 12 standards reviewed, **McKesson** met all of the elements for the following 5 standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education. **McKesson** received a ***Partially Met*** for one or more elements contained in the remaining 7 of the 12 standards reviewed.

- HSAG recommends that **McKesson** prioritizes improvement efforts to address deficiencies in the following standards: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to PCPs, Provider Services, Care Transitions, and Operational Structure and Reporting. These standards must be addressed in **McKesson**'s Corrective Action Plan, which is described in the section below.

During the on-site review, HSAG reviewers discussed with **McKesson** staff the length of time that passes between a person's enrollment in the program and when the person's care needs are assessed. In the case of pregnant enrollees, the pregnancy is time-limited so the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the time the woman was enrolled in the program and when her needs were assessed. In one notable instance, HSAG reviewers found that 154 days had passed between the date of enrollment and the date of assessment for one pregnant woman, and the enrollee already gave birth by the time her care management needs were assessed.

- HSAG recommends that **McKesson** establish a reasonable standard (number of days between enrollment and assessment) to ensure pregnant enrollees' needs are assessed more quickly. **McKesson** should obtain DHCFP's approval of the standard. Further **McKesson** should monitor the standard on an ongoing basis.

During both the Readiness Review and the Compliance Review, HSAG found the quality of staff proposed for the program to be consistent with contractual requirements. Further, HSAG found that **McKesson** maintained appropriate written descriptions for developing and operating multidisciplinary care management teams. The quantity of staff designated to the program, however, was inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the number of persons enrolled in the program (39,543). Based on the anticipated staffing need for the HCGP noted in Table 8 (63.11 FTEs) and the number of staff designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing is 39.01 FTEs.

- HSAG recommends that **McKesson** evaluate the quantity of staff designated to the Nevada HCGP program and ensure that the staffing ratios proposed for the program are consistent with the number of FTEs designated to the HCGP program, given the number of persons enrolled in the program.

For the checklist review, **McKesson** scored 100 percent for all elements contained in Checklist I: Transitioning Recipients into Care Management. For Checklist II: Required Reports, **McKesson** scored 41.7 percent, which showed that **McKesson** did not meet most the required elements for reporting to DHCFP. In some cases, the same opportunities for improvement were noted in the

Readiness Review findings and had not been remedied by at the time of the on-site compliance review.

- HSAG recommends that **McKesson** review the remediation plan **McKesson** submitted on April 10, 2014 to become familiar with the strategies **McKesson** identified to correct the issues identified during the Readiness Review. Further, **McKesson** should develop the required reports and submit them to DHCFP for approval to ensure that **McKesson**'s proposed format for the reports meets the needs of DHCFP staff for reporting to CMS.

For the care management file review, **McKesson** received a score of 79.2% for Section IV: Ongoing Care Management. The elements in this section require the CMO to document evidence of ongoing communication with the enrollee and his/her PCP. In many cases, additional follow-up with the PCP was not documented.

- HSAG recommends that **McKesson** communicate with each enrollee's identified PCP, document all communication with the PCP in the care management file, and notify the PCP when the enrollee cannot be reached or is not complying with care management goals and objectives.

The results of the grievance file review indicated that all notes concerning the investigation and resolution of the grievances were not documented in the grievance files. Further, the files did not always contain the date the grievance was resolved, and they did not contain notification to the enrollee concerning the resolution of the grievance.

- HSAG recommends that **McKesson** staff record all notes in the grievance files and also notify enrollees when the grievance is resolved. **McKesson** should also record the date the grievance was resolved and closed in the respective grievance file.

Corrective Action

HSAG provided recommendations for each review element that received a score of ***Partially Met***. There were no elements found ***Not Met***. HSAG's findings and recommendations for each of the elements contained for each Standard may be found in Attachment A of this report. To propose its plan to correct any elements that received a score of ***Partially Met***, **McKesson** must use the template provided in Attachment E to submit its Corrective Action Plan (CAP) to the DHCFP and address each of the items that included a recommendation.

In addition to completing the template found in Attachment E, **McKesson** must submit its planned approach to address the recommendations detailed in the Conclusions and Recommendations section above.

McKesson must submit its Corrective Action Plan to the DHCFP **within 21 days of receiving this report**. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **McKesson** in its submitted CAP.

Attachment F

HSAG's NCQA HEDIS (CAHPS) Survey Vendor Certificate

As referenced in Section V, 2.2.7.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2017
DATE GRANTED

October 31, 2018
EXPIRATION DATE

Attachment G

DATASTAT'S NCQA HEDIS (CAHPS) SURVEY VENDOR CERTIFICATE

As referenced in Section V, 2.2.7.

National Committee for Quality Assurance

recognizes

DataStat

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2017
DATE GRANTED

October 31, 2018
EXPIRATION DATE

Attachment H

LICENSED ORGANIZATION CERTIFICATE

As referenced in Section V 2.2.8

National Committee for Quality Assurance

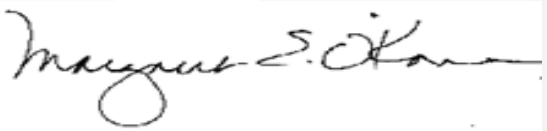
is pleased to announce

Health Services Advisory Group, Inc.

fulfilled all the necessary requirements
to conduct NCQA HEDIS® Compliance Audits™
and attained the designation of

NCQA-LICENSED ORGANIZATION

MARGARET E. O' KANE
PRESIDENT



DATE LICENSED: 11/1/2017 **EXPIRATION DATE:** 10/31/18

Attachment I

PROJECT TEAM ORGANIZATIONAL CHART

As referenced in Section V, 2.3.1.

HSAG Nevada Project Team Organization Chart

★ = Key Staff
◆ = NCQA-Certified HEDIS Compliance Auditor

President and Chief Executive Officer
◆ M. Dalton, PhD, MBA, RN, CHCA

Chief Data Officer & Vice President, Data Science & Advanced Analytics (DSAA)
T. Laios, MBA, MPH

Chief Operating Officer, Executive Vice President
◆ R. Potter, MBA, CPA, CHCA

IT Department Chief Technology Officer

Senior Executive Director
C. Smallwood, MPH

Contract Manager
★ **G. Thompson, MBA, CPHQ**

Reports Team

Performance Improvement Project (PIP) Validation/ Conduct PIPs

★ **C. Melendez, ANS, RN, CPHA Director, PIPs**
Director (1)
Associate Director (1)
Project Manager (1)

HEDIS Performance Measure Validation

◆ ★ **M. Badani, MBA, CHCA Director, Audits**
Directors (2)
HEDIS Manager (1)
Source Code Reviewer (1)

Compliance Monitoring of MCO, DBA/PAHP, CMO

★ **G. Thompson, MBA, CPHQ Contract Manager**
Directors/Reviewers (4)

Network Adequacy Validation

★ **A. Kearney, BA Director, DSAA**
Director (1)
Associate Director (1)
Analytics Manager (1)
Healthcare Analysts (2)
Project Support Specialist (1)

HEDIS Comparative Analysis

★ **R. Berens, BA Associate Director, DSAA**
Associate Director (1)
Analytics Manager (1)
Informatics Analyst (1)

Encounter Data Validation

★ **A. Kearney, BA Director, DSAA**
Director (1)
Sr. Healthcare Analyst (1)
Healthcare Analysts (2)
Project Support Specialist (1)

Consumer and/or Provider Surveys/CAHPS

★ **A. Saldivar, MHSM Director, DSAA**
Director (1)
Analytics Manager (1)
Analysts (2)

Subcontractor
DataStat, Inc

Calculation of Performance Measures

★ **R. Berens, BA Associate Director, DSAA**
Associate Director (1)
Analyst Manager (1)
Analysts (2)
Analyst Coordinator (1)

Quality Studies

★ **A. Kearney, BA Director, DSAA**
Director (1)
Associate Director (1)
Healthcare Analysts (2)
Project Support Specialist (1)

Quality Rating System

★ **R. Berens, BA Associate Director, DSAA**
Associate Director (1)
Analytics Manager (1)
Analyst (1)

Validation of QAPIS Strategy

★ **G. Thompson, MBA, CPHQ Contract Manager**
Directors (3)

Annual Technical Report

★ **G. Thompson, MBA, CPHQ Contract Manager**
Directors (4)

Quality Activities related to ABD and/or TANF/CHAP

★ **G. Thompson, MBA, CPHQ Contract Manager**
Directors (4)

Technical Assistance

★ **G. Thompson, MBA, CPHQ Contract Manager**
Directors (5)
Associate Director (1)

Attachment J

CURRENT YEAR INTERIM

As referenced in Section VI, 3.1.11.

HEALTH SERVICES HOLDINGS, INC.
CONSOLIDATED BALANCE SHEET
2018 Fiscal Year Through December 31, 2017
Unaudited

	HSH	HSAG	Inter Co. Eliminations	Unaudited Total
Current Assets				
Cash in Bank	$ 17,270	$ 3,360,554	$ -	$ 3,377,824
Accounts Receivable	-	15,091,244	-	15,091,244
Work-In-Process	-	3,089,277	-	3,089,277
Other A/R	1,725	3,894,220	(2,368,415)	1,527,530
Due from Affiliate	-	-	-	-
Other Assets	-	167,454	-	167,454
Prepaid expenses	557,492	1,107,985	-	1,665,477
Total Current Assets	576,487	26,710,734	(2,368,415)	24,918,806
Long Term Assets				
Equipment, net of depreciation	865,251	2,951,326	-	3,816,577
Deferred Taxes	2,277,365	1,201,856	-	3,479,221
Long Term Receivables	-	-	-	-
Long Term Investment Less Amortization	-	-	-	-
Total Long Term Assets	3,142,616	4,153,182	-	7,295,798
Total Assets	$ 3,719,103	$ 30,863,916	$ (2,368,415)	$ 32,214,604
Liabilities and Stockholders' Equity				
Current Liabilities				
A/P - Trade	25,155	$ 818,639		$ 843,794
Due to Affiliate	-	-	-	-
Credit Line	-	-	-	-
Accrued Payroll	3,995,519	3,046,006	-	7,041,525
Fringe and Leave Accruals	195,160	1,738,550	-	1,933,710
Debt, Current Portion	-	-	-	-
Other Liabilities	2,499,489	2,134,094	(2,368,415)	2,265,168
Income Taxes Payable	(767,745)	1,017,366	-	249,621
Billings in Excess of Cost	-	3,483,445	-	3,483,445
Total Current Liabilities	5,947,578	12,238,100	(2,368,415)	15,817,263
Long Term Liabilities				
Loan - Long Term Portion	-	-	-	-
Note Payable	5,756,869	-	-	5,756,869
Deferred Rent	-	1,377,523	-	1,377,523
Contingent Liability - Legal Expense Reim.	-	-	-	-
Deferred Income Taxes	100,626	132,004	-	232,630
Total Long Term Liabilities	5,857,495	1,509,527	-	7,367,022
Total Liabilities	11,805,073	13,747,627	(2,368,415)	23,184,285
Stockholders' Equity				
Common stock	-	3,232	-	3,232
Additional Paid in Capital	16,970	-	-	16,970
Prior Years' Earnings	(6,937,672)	15,701,907	-	8,764,235
Unissued ESOP Shares	-	-	-	-
Current Year's Earnings	(1,165,268)	1,411,150	-	245,882
Total Stockholders' Equity	(8,085,970)	17,116,289	-	9,030,319
Total Liabilities and Stockholders' Equity	$ 3,719,103	$ 30,863,916	$ (2,368,415)	$ 32,214,604

HEALTH SERVICES HOLDINGS, INC.
CONSOLIDATING STATEMENT OF INCOME
2018 Fiscal Year Through December 31, 2017
Unaudited

	HSH	HSAG	ELMINATIONS	TOTAL
	YTD	YTD	YTD	YTD
SERVICE REVENUES				
Federal Revenue		$ 30,570,263	$ -	$ 30,570,263
State & Corporate Revenue		10,191,282	-	10,191,282
LEC Revenue		5,581,117	-	5,581,117
TOTAL SERVICE REVENUES		46,342,662	-	46,342,662
DIRECT COSTS				
Labor		16,675,481	-	16,675,481
Leave		3,207,137	-	3,207,137
Fringe		4,308,494	-	4,308,494
Travel		449,292	-	449,292
Consultants		4,316,754	-	4,316,754
Other Direct Costs		368,048	-	368,048
TOTAL DIRECT COSTS		29,325,206	-	29,325,206
GROSS MARGIN		17,017,456	-	17,017,456
ADMINISTRATIVE EXPENSES				
Labor	1,061,297	3,495,324		4,556,621
Leave / Fringe	149,214	1,575,341		1,724,555
Other Administrative Expenses	201,828	9,587,397		9,789,225
TOTAL ADMINISTRATIVE EXPENSES	1,412,339	14,658,062	-	16,070,401
INCOME/(LOSS) FROM OPERATIONS	(1,412,339)	2,359,394	-	947,055
OTHER INCOME / (EXPENSES)				
Interest Income	-	79	-	79
Other Income	1,113	410	-	1,523
Interest (Expense)	(130,887)	(7,967)		(138,854)
Gain (Loss) on Asset Disposals	-	-		-
TOTAL OTHER INCOME / (EXPENSES)	(129,774)	(7,478)	-	(137,252)
INCOME/(LOSS) BEFORE INCOME TAXES	(1,542,113)	2,351,916	-	809,803
INCOME TAXES	(376,845)	940,766	-	563,921
NET INCOME/(LOSS)	$ (1,165,268)	$ 1,411,150	$ -	$ 245,882

Attachment K

HSAG – 2017 Fiscal Year Financial Statements

As referenced in Section VI, 3.1.11.

HEALTH SERVICES HOLDINGS, INC.
AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS
AND ADDITIONAL INFORMATION

Years Ended June 30, 2017, 2016 and 2015

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS AND ADDITIONAL INFORMATION

Years Ended June 30, 2017, 2016, and 2015

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholders of

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

We have audited the accompanying consolidated financial statements of ***Health Services Holdings, Inc. and Subsidiary***, which comprise the consolidated balance sheets as of June 30, 2017, 2016, and 2015, and the related consolidated statements of income and retained earnings, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of ***Health Services Holdings, Inc. and Subsidiary*** as of June 30, 2017, 2016, and 2015, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Consolidating Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet as of June 30, 2017 and consolidating statement of income and retained earnings for the year then ended are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements.

Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Emphasis of Matter

As discussed in Note 1 to the financial statements, ***Health Services Holdings, Inc. and Subsidiary*** adopted ASU No. 2015-17 as of June 30, 2017, 2016 and 2015, and for the years then ended. Our opinion is not modified in respect to this matter.

Mayer Hoffman McCann P.C.

October 18, 2017

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATED BALANCE SHEETS

June 30, 2017, 2016, and 2015

ASSETS

	2017	2016	2015
CURRENT ASSETS			
Cash and cash equivalents	$ 4,799,329	$ 4,976,536	$ 3,919,783
Receivables	21,748,334	19,529,233	19,140,754
Prepaid expenses and other current assets	1,360,018	1,522,083	1,646,839
Income taxes receivable	-	27,712	1,648
TOTAL CURRENT ASSETS	27,907,681	26,055,564	24,709,024
PROPERTY AND EQUIPMENT, net	4,461,292	5,049,508	4,099,992
DEFERRED INCOME TAXES	3,246,591	2,763,151	2,829,712
OTHER ASSETS	179,354	163,597	163,597
TOTAL ASSETS	$ 35,794,918	$ 34,031,820	$ 31,802,325

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES			
Accounts payable	$ 1,966,951	$ 2,789,532	$ 4,142,630
Accrued expenses	13,210,756	10,823,130	9,095,947
Income taxes payable	110,131	34,000	981,949
Deferred revenues	2,299,145	3,069,719	3,987,199
Other current liabilities	2,152,486	1,772,095	1,772,095
TOTAL CURRENT LIABILITIES	19,739,469	18,488,476	19,979,820
DEFERRED RENT	1,514,144	1,695,264	1,747,097
NOTES PAYABLE - STOCKHOLDERS	5,756,869	5,721,536	2,506,605
TOTAL LIABILITIES	27,010,482	25,905,276	24,233,522
COMMON STOCK, par value $1, authorized 1,000,000 shares, issued and outstanding 3,232 shares	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	16,970	16,970
DEFERRED COMPENSATION EXPENSE	-	(461,980)	(841,980)
RETAINED EARNINGS	8,764,234	8,568,322	8,390,581
TOTAL STOCKHOLDERS' EQUITY	8,784,436	8,126,544	7,568,803
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 35,794,918	$ 34,031,820	$ 31,802,325

See Notes to Consolidated Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF INCOME AND RETAINED EARNINGS

Years Ended June 30, 2017, 2016, and 2015

	2017	2016	2015
SERVICE REVENUES			
Federal contracts	$ 71,064,634	$ 61,193,167	$ 55,053,974
State and corporate contracts	24,282,179	23,369,481	23,323,387
TOTAL SERVICE REVENUES	95,346,813	84,562,648	78,377,361
DIRECT EXPENSES	58,831,488	52,593,968	50,774,860
GROSS MARGIN	36,515,325	31,968,680	27,602,501
ADMINISTRATIVE EXPENSES	35,711,502	31,498,630	27,159,385
INCOME FROM OPERATIONS	803,823	470,050	443,116
OTHER EXPENSE	(520,892)	(125,573)	(50,763)
INCOME BEFORE INCOME TAXES	282,931	344,477	392,353
INCOME TAXES			
Current provision	570,459	100,175	1,153,057
Deferred provision (benefit)	(483,440)	66,561	(999,021)
TOTAL INCOME TAXES	87,019	166,736	154,036
NET INCOME	195,912	177,741	238,317
RETAINED EARNINGS, BEGINNING OF YEAR	8,568,322	8,390,581	8,152,264
RETAINED EARNINGS, END OF YEAR	$ 8,764,234	$ 8,568,322	$ 8,390,581

See Notes to Consolidated Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended June 30, 2017, 2016, and 2015

	2017	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	$ 195,912	$ 177,741	$ 238,317
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	1,618,846	1,467,220	1,146,162
Change in deferred income taxes	(483,440)	66,561	(999,021)
Loss on disposition of fixed assets	-	1,616	123,115
Additional cash received on disposition of fixed assets	10,959	-	-
Increase in notes payable - stockholders due to accrued interest	250,264	214,931	46,406
Changes in operating assets and liabilities:			
Decrease (increase) in:			
Receivables	(2,219,101)	(388,479)	(1,611,542)
Prepaid expenses and other current assets	162,065	124,756	(534,047)
Income taxes receivable	27,712	(26,064)	48,826
Increase (decrease) in:			
Accounts payable	(462,808)	(862,874)	488,464
Accrued expenses	2,387,626	1,727,183	2,279,503
Deferred revenues	(770,574)	(917,480)	29,332
Income taxes payable	76,131	(947,949)	-
Other current liabilities	380,391	-	322,306
Deferred rent	(181,120)	(51,833)	318,036
Net cash provided by operating activities	992,863	585,329	1,895,857
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchases of property and equipment	(1,401,362)	(2,908,576)	(812,870)
Change in other assets	(15,757)	-	(7,706)
Net cash used in investing activities	(1,417,119)	(2,908,576)	(820,576)
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments on capital lease obligation	-	-	(89,166)
Payments on notes payable - stockholders	(214,931)	-	-
Proceeds from notes payable - stockholders	-	3,000,000	1,000,000
Change in deferred compensation expense	461,980	380,000	380,000
Net cash provided by financing activities	247,049	3,380,000	1,290,834
NET CHANGE IN CASH AND CASH EQUIVALENTS	(177,207)	1,056,753	2,366,115
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	4,976,536	3,919,783	1,553,668
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 4,799,329	$ 4,976,536	$ 3,919,783
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid for interest	$ 12,902	$ 7,574	$ 31,664
Cash paid for income taxes	$ 483,396	$ 1,077,997	$ 123,664
SUPPLEMENTAL DISCLOSURE OF NON-CASH INVESTING AND FINANCING ACTIVITIES			
Increase in notes payable - stockholders due to accrued unpaid interest	$ 250,264	$ 214,931	$ 46,406
Purchases of property and equipment included in accounts payable	$ 22,753	$ 382,526	$ 872,750

See Notes to Consolidated Financial Statements

(1) Company operations and summary of significant accounting policies

Company operations - ***Health Services Holdings, Inc. and Subsidiary*** (the "Company") is engaged in providing health care information in Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Louisiana, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, U.S. Virgin Islands, Utah, Vermont, Virginia, Washington and Wyoming. Company efforts are designed to improve the quality of health care through the study of information.

The significant accounting policies followed by the Company are summarized below:

Principles of consolidation - The accompanying consolidated financial statements include the accounts of ***Health Services Holdings, Inc.*** (“HSH”), ***Health Services Advisory Group, Inc.*** (“HSAG”), and ***Health Services Advisory Group of California, Inc.*** (“HSAG-CA”). In February 2004, HSH was established as a holding company of HSAG. The transactions to establish HSH resulted in the stockholders of HSAG becoming the majority stockholders of HSH. This transaction was accounted for under the rules applying to reverse acquisition accounting, under which HSAG’s historical financial statement balances are carried forward as the financial reporting parent under the legal parent entity’s name (HSH). As of August 1, 2014, HSAG-CA was administratively dissolved. The operations of the entity that was required to continue was consolidated into and performed by HSAG. All significant intercompany transactions and accounts have been eliminated in consolidation.

Management’s use of estimates - The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenue recognition - The Company recognizes revenue as services are performed. Cash received for future services is deferred until the service has been performed. The Company’s contracts with the Department of Health and Human Services are on a cost-plus-fee basis, fixed price basis, or cost only basis. Therefore, revenues for the contracts are recognized to the extent reimbursable costs are incurred and estimated fees are earned if applicable. Billings in excess of reimbursable costs incurred plus estimated fees are recorded as deferred revenue. Provisions for estimated losses on contracts are recognized in the period in which such losses are determined.

Costs related to certain contracts are subject to adjustment based on negotiations with, and the audits of the Company’s records by its customers, including representatives of the federal government. Revenues for such contracts are recorded in amounts that are expected to be realized. It is reasonably possible that some portion of revenues recorded in the current period may be disallowed in future periods as a result of audits performed by the Company’s customers. These disallowed revenues may be required to be refunded to the customer upon final settlement of the contract.

Cash and cash equivalents - Cash includes cash and, at times, cash equivalents which consist of highly liquid debt instruments purchased with original maturities of three months or less. Cash deposits are insured up to $250,000 by the Federal Deposit Insurance Corporation (FDIC).

(1) Company operations and summary of significant accounting policies (continued)

Receivables - Receivables are carried at the outstanding balances less an allowance for doubtful accounts. The Company evaluates the collectability of its receivables based on a combination of factors. In circumstances where it is aware of a specific customer's inability to meet its financial obligations, the Company records a specific reserve to reduce the amounts recorded to what is estimated to be collected. Accounts are charged off against the allowance when they are deemed to be uncollectible. Accounts receivable at June 30, 2017, 2016, and 2015 are considered by management to be collectible in full and, accordingly, an allowance for doubtful accounts is not necessary.

Depreciation and amortization - Depreciation and amortization is computed using straight-line and accelerated methods over the following estimated useful lives:

Furniture and equipment	3 - 10 years
Leasehold improvements	2 - 10 years
Equipment held under capital lease	5 years

Impairment of long-lived assets - The Company accounts for long-lived assets in accordance with the provisions of FASB ASC 360, *Property, Plant, and Equipment*, which requires that long-lived assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. No impairment charges were recorded for the years ended June 30, 2017, 2016, and 2015.

Deferred rent - Deferred rent represents the difference between the total rent payments amortized using the straight-line method over the life of the leases and the actual cash expenditures.

Income taxes - The Company follows FASB ASC 740, *Income Taxes*. FASB ASC 740 requires an asset and liability approach for financial accounting and reporting for income tax purposes. This statement recognizes (a) the amount of taxes payable or refundable for the current year, and (b) deferred tax liabilities and assets for future tax consequences of events that have been recognized in the consolidated financial statements or tax returns.

The Company accounts for uncertainty in income taxes through the application of a "more likely than not" threshold to the recognition and derecognition of uncertain tax positions. The provisions require that a change in judgment related to the expected ultimate resolution of uncertain tax positions be recognized in earnings in the year of such change. The Company's policy is to classify income tax penalties and interest as interest expense in its consolidated financial statements. At June 30, 2017, 2016, and 2015, the Company did not have any unrecognized tax benefits.

The Company files income tax returns in the U.S. federal jurisdiction and various state and local jurisdictions. The Company is no longer subject to U.S. federal and state and local income tax examinations by tax authorities for years before 2012.

(1) Company operations and summary of significant accounting policies (continued)

Fair value measurements - The Company currently has no assets or liabilities subject to fair value measurement other than at initial recognition.

Recently issued accounting pronouncements - The Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09 – *Revenue from Contracts with Customers (Topic 606)* (ASU 2014-09) in May 2014, as amended, which is effective for nonpublic entities for annual reporting periods beginning after December 15, 2018, which would be the fiscal year ending June 30, 2020 for the Company.. The FASB is currently undertaking efforts to provide implementation guidance to preparers of financial statements. The Company has not completed the process of evaluating the impact that will result from adopting ASU 2014-09 and is therefore unable to disclose the effects of adoption, if any, on the consolidated financial statements. During 2017, the Company anticipates establishing an implementation team to identify potential differences that could result from applying the requirements of this new standard, together with adoption of ASU No 2014-09. The team will be responsible for identifying and implementing changes to business processes, systems, and controls to support disclosure under the new standard and evaluate any effect the new guidance will have on the Company's consolidated financial position.

In November 2015, the FASB issued ASU No. 2015-17, *Balance Sheet Classification of Deferred Taxes*, which requires entities with a classified balance sheet to present all deferred tax assets and liabilities as noncurrent. The new pronouncement for entities other than public business entities is effective for fiscal years beginning after December 15, 2017, which would be the fiscal year ending June 30, 2019 for the Company. FASB permits early adoption at the beginning of an interim or annual period. The Company elected early adoption effective June 30, 2017, which requires a retrospective application. Accordingly, the Company reclassified deferred tax assets totaling $2,666,739 and $2,266,118 as of June 30, 2016 and 2015, respectively, from current to noncurrent assets to conform to the new presentation requirements.

In February 2016, the FASB issued ASU No. 2016-02 – *Leases (Topic 842)*. ASU 2016-02 requires that a lease liability and a related right-of-use asset representing the lessee's right to use or control the asset be recorded on the balance sheet upon the commencement of all leases except for short-term leases. Leases will be classified as either finance leases or operating leases, which are substantially similar to the classification criteria for distinguishing between capital leases and operating leases in existing lease accounting guidance. As a result, the effect of leases in the statement of operations and the statement of cash flows will be substantially unchanged from the existing lease accounting guidance. ASU 2016-02 is effective for fiscal years beginning after December 15, 2019, which would be the fiscal year ending June 30, 2021 for the Company. Early adoption is permitted. The Company has not elected to adopt this standard early. The Company has estimated that if they were to adopt the standard, a non-current operating lease right-of-use asset of approximately $12.4 million and corresponding current and non-current operating lease liabilities of $3.2 million and $9.2 million, respectively, would be recorded in the accompanying consolidated balance sheet as of June 30, 2017. The estimate was calculated using the minimum future lease payments (see Note 10) and a discount rate representing the Company's incremental borrowing rate (see Note 4). In accordance with ASU 2016-02, operating leases are expected to record a single lease cost, identified as lease expense, in the statement of operations, and payments arising from such operating leases are generally included within operating activities in the statement of cash flows.

Subsequent events - The Company has evaluated subsequent events through October 18, 2017, which is the date the consolidated financial statements were available to be issued.

(2) Receivables

Receivables consist of:

	2017	2016	2015
Contracts receivable:			
State and corporate contracts	$ 13,359,504	$ 11,440,044	$ 9,376,315
Federal contracts	8,209,376	8,013,680	9,761,339
Total contracts receivable	21,568,880	19,453,724	19,137,654
Other receivables	179,454	75,509	3,100
Total receivables	$ 21,748,334	$ 19,529,233	$ 19,140,754

The contracts receivable amounts above include billed and unbilled amounts as follows:

	2017	2016	2015
Billed	$ 17,607,304	$ 16,487,076	$ 14,840,180
Unbilled	2,534,096	1,719,061	3,201,603
Retainage	1,427,480	1,247,587	1,095,871
Total contracts receivable	$ 21,568,880	$ 19,453,724	$ 19,137,654

(3) Property and equipment

Property and equipment consists of:

	2017	2016	2015
Cost:			
Furniture and equipment	$ 8,266,735	$ 9,879,861	$ 8,096,297
Leasehold improvements	2,172,755	2,003,921	1,866,066
Assets in process	4,849	215,365	73,070
Total cost	10,444,339	12,099,147	10,035,433
Accumulated depreciation and amortization	(5,983,047)	(7,049,639)	(5,935,441)
Net property and equipment	$ 4,461,292	$ 5,049,508	$ 4,099,992

Depreciation and amortization expense charged to operations was $1,618,846, $1,467,220, and $1,146,162, for the years ended June 30, 2017, 2016, and 2015, respectively.

(4) Lines of credit

In May 2012, the Company entered into revolving lines of credit of $3,850,000, $1,150,000, and $1,150,000. All three lines of credit charged interest at LIBOR plus 2.75% (3.92%, 3.20%, and 2.90% at June 30, 2017, 2016 and 2015, respectively), or 4.25% if greater, payable monthly. The lines of credit matured in April 2015 and were replaced by an amended and restated revolving line of credit with a borrowing capacity of $6,150,000, maturing in February 2018. The amended line of credit bears an interest rate of LIBOR plus 2.50% and is secured by property and equipment, receivables and common stock of the Company. The line of credit is also guaranteed personally by certain stockholders of the Company. The lines of credit were subject to various financial and non-financial covenants. At June 30, 2017, 2016 and 2015, there was $0 of borrowings outstanding on the line of credit.

(4) Lines of credit (continued)

The Company had unexpired financial standby letters of credit through its bank at June 30, 2017, 2016, and 2015. The letters of credit expire annually, with automatic annual extensions unless notification is made 60 to 90 days in advance. The Company had standby letters of credit available of approximately $222,000 at June 30, 2017 and $1,435,000 at June 30, 2016 and June 30, 2015. The available balance to draw from the revolving line of credit described above is reduced by these letters of credit.

(5) Notes payable - stockholders

During 2011, the Company borrowed $1,395,000 from the majority stockholder of the Company and signed a promissory note to the majority stockholder, in which unpaid principal accrues interest at 3% per annum, compound annually. During 2015, the Company borrowed an additional $1,000,000 and amended the promissory note such that unpaid principal accrues interest at 4% per annum. The note is unsecured and the outstanding principal and interest is due in June 2020. The outstanding principal and interest balance was $2,606,869, $2,609,036, and $2,506,605, at June 30, 2017, 2016, and 2015, respectively.

During 2016, the Company borrowed $3,000,000 from the majority stockholder of the company and signed a promissory note to the majority stockholder, in which unpaid principal accrues at 5% per annum, compounded annually. The outstanding principal and interest balance was $3,150,000 and $3,112,500 at June 30, 2017 and 2016, respectively. The note is unsecured and matures on March 30, 2020.

Annual maturities on the outstanding notes payable - stockholders are as follows:

Fiscal Year	
2018	$ -
2019	-
2020	5,756,869
Total annual maturities	$ 5,756,869

Total interest expense recognized on these notes payable was $250,264, $214,931, and $46,406, for the years ended June 30, 2017, 2016, and 2015, respectively.

(6) Other current liabilities

During the years ended June 30, 2007 through 2015 and during the year ended June 30, 2017, the Defense Contract Audit Agency (“DCAA”), working under directive from the Centers for Medicare and Medicaid Services (“CMS”), audited the costs charged to a CMS contract and recommended to CMS that certain costs be disallowed that were included in the general and administration cost pool as well as employee compensation costs. Included within these disallowed costs are certain costs related to the final settlement of a lawsuit from one former executive and the partial settlement of a lawsuit from another executive. While CMS is not obligated to follow the recommendations of the DCAA, management has determined that CMS will disallow the costs.

(6) Other current liabilities (continued)

The liabilities recognized as a result of these matters consists of the following:

	2017	2016	2015
Disallowed costs related to legal settlements	$ 744,698	$ 744,698	$ 744,698
DCAA audit accrual for 2007 and 2008	140,497	140,497	140,497
DCAA audit accrual for 2008	331,804	331,804	331,804
DCAA audit accrual for 2010 and 2011	76,461	76,461	76,461
DCAA audit accrual for 2011	322,306	322,306	322,306
DCAA audit accrual for 2012	290,375	156,329	156,329
DCAA audit accrual for 2013	75,091	-	-
DCAA audit accrual for 2014	171,254	-	-
	$ 2,152,486	$ 1,772,095	$ 1,772,095

(7) Other income (expense)

Other income (expense) consists of:

	2017	2016	2015
Interest expense	$ (263,166)	$ (222,505)	$ (78,070)
Interest income	106,741	64,851	16,861
DCAA audit accruals (Note 6)	(380,391)	-	-
Other income	15,924	32,081	10,446
Total other income (expense)	$ (520,892)	$ (125,573)	$ (50,763)

(8) Income taxes

Income taxes are provided for the tax effects of transactions reported in the consolidated financial statements and consist of taxes currently due plus deferred income taxes related primarily to differences between the financial and tax basis of property and equipment, deferred rent and certain accrued expenses, and the availability of net operating loss carryovers. The deferred taxes represent the future tax return consequences of these differences, which will either be taxable or deductible when the assets and liabilities are recovered or settled.

Deferred income tax assets are attributable to the following:

- As of June 30, 2016, the Company no longer has any state operating loss carryovers. State operating loss carryovers were approximately $256,000 as of June 30, 2015 and provided future income tax benefits as they were applied against future state taxable income.

- Obligations for certain accrued expenses have no tax basis. Those accrued expenses will be deductible as payments are made in future periods.

- Expenses recorded for rents related to the deferred rent liability have no tax basis. The rent expense will be deductible as payments are made in future periods.

(8) Income taxes (continued)

Deferred income tax liabilities are attributable to the following:

- The basis of property and equipment for financial reporting exceeds its basis for tax purposes by the cumulative amount of the income tax depreciation and amortization over financial reporting depreciation and amortization. The excess will be taxable in future periods through reduced depreciation and amortization deductions for tax purposes.

- Retainage included as revenue in the consolidated statement of income is taxed when collected. The retainage recognized for income tax purposes is adjusted to exclude the amount of uncollected retainage that has yet to be recognized for tax purposes.

The provision for income taxes consist of:

	2017	2016	2015
Current provision:			
Federal	$ 471,458	$ 70,790	$ 973,545
State	99,001	29,385	179,512
Total current provision	570,459	100,175	1,153,057
Deferred provision (benefit)			
Federal	(416,125)	64,024	(872,278)
State	(67,315)	2,537	(126,743)
Total deferred provision (benefit)	(483,440)	66,561	(999,021)
Total income taxes	$ 87,019	$ 166,736	$ 154,036

The components of deferred tax assets and liabilities included in the accompanying consolidated balance sheets are as follows:

	2017	2016	2015
Deferred income tax assets (liabilities):			
Accrued expenses	$ 3,263,331	$ 2,666,739	$ 2,266,118
Property and equipment	(449,952)	(388,323)	(129,172)
Net operating loss carryovers	-	-	14,077
Contracts receivable, retainage	(153,460)	(173,480)	-
Deferred rent	586,672	658,215	678,689
Net deferred income tax assets	$ 3,246,591	$ 2,763,151	$ 2,829,712

(8) Income taxes (continued)

The provision for federal income taxes differs from that computed by applying federal statutory rates to income before federal income tax expense, as indicated in the following analysis:

	2017	2016	2015
Federal statutory income tax at 34%	$ 96,197	$ 117,122	$ 133,399
Effect of state income taxes	11,927	11,559	14,536
Adjustments related to prior year true-ups	(7,280)	11,704	(1,936)
Effect of non-deductible meals, travel, and entertainment	11,999	20,192	15,284
State tax credit	(20,845)	-	(13,200)
Other	(4,979)	6,159	5,953
Total provision for income taxes	$ 87,019	$ 166,736	$ 154,036

(9) Employee benefit plans

The Company has a profit-sharing plan covering employees who meet specified age and service requirements. Contributions to the profit-sharing plan are determined annually at the discretion of the Company's Board of Directors. The matching contributions made by the Company were $758,247, $644,671, and $647,045, for the years ended June 30, 2017, 2016, and 2015, respectively.

The Company has an employee stock ownership plan (ESOP) covering employees who meet specified age and service requirements. Contributions are determined annually at the discretion of the Company's Board of Directors.

Effective December 31, 2008, the Health Services Holdings, Inc. Employee Stock Ownership Plan (ESOP) became a leveraged plan. The purchase was structured with a blend of cash and debt. To facilitate the sale, HSH loaned the ESOP $3,800,000 and a stockholder loaned the ESOP $539,773. The ESOP shares were pledged as collateral on the aggregate amount borrowed of $4,339,773, which was initially recorded as deferred compensation expense in the accompanying consolidated balance sheets. As debt was repaid to HSH and the stockholder, shares were released from collateral and allocated to active employees, based on their compensation. The Company funds the ESOP through contributions authorized by the Company. The Company made contributions to the ESOP of $1,761,860, $1,523,354, and $1,457,427, for the years ended June 30, 2017, 2016, and 2015, respectively. The ESOP loan has been repaid in full as of June 30, 2017.

At June 30, 2017, 970 shares held by the ESOP have been released to the plan's participants. The participants have a limited put option right to the Company that would require the Company to repurchase its common stock from participants in the ESOP who are eligible to receive benefits under the terms of the plan and elect to receive cash for their common stock. The potential commitment for the put option at June 30, 2017 is approximately $10,900,000.

(10) Leases

The Company leases office space and equipment under operating leases expiring in various years through fiscal year 2025. Minimum future rental payments under noncancellable operating leases having remaining terms in excess of one year including leases entered into by the Company through the date of this report are as follows:

Years Ending June 30,	
2018	$ 3,334,290
2019	3,330,892
2020	3,345,760
2021	1,198,268
2022	833,274
Thereafter	1,809,398
Total minimum future rental payments	$ 13,851,882

Total rental expense under operating leases with terms in excess of one month was $3,254,154, $3,159,805, and $3,496,600, for the years ended June 30, 2017, 2016, and 2015, respectively.

Some of the operating leases above contain renewal options while others make no provision for renewal options. In the normal course of business the Company will either renew leases or seek other arrangements.

(11) Concentrations

The Company generates a substantial portion of its revenues from contracts with the federal government. The Company is the sole provider of Quality Improvement Network (QIN) review services in Arizona, Florida California, Ohio, and the U.S. Virgin Islands under specific contracts with the federal government's Centers for Medicare and Medicaid Services (CMS). In addition, the Company holds several contracts with CMS, or a subcontractor to CMS.

During the years ended June 30, 2017, 2016, and 2015 revenues from contracts with CMS were $70,792,328, $61,193,167, and $54,769,250, respectively. Amounts due from CMS contracts included in receivables were $8,209,376, $8,013,680, and $9,761,339 as of June 30, 2017, 2016, and 2015, respectively.

If the Company were unable to maintain current or future contracts, the Company's operations could be substantially affected.

(12) Commitments and contingencies

All of the Company's assets and stock are pledged as collateral on certain debt arrangements held by the Company.

Contract revenue received on government contracts is subject to future audits and adjustments by government audit agencies. Any disallowed costs, including amounts already collected, may constitute a liability of the Company. The amount of costs and related revenue that may be disallowed by future government audits cannot be determined at this time. However, the Company expects such amounts, if any, to be immaterial.

ADDITIONAL INFORMATION

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATING BALANCE SHEET

June 30, 2017
(with consolidated totals for June 30, 2016, and 2015)

ASSETS

	Health Services Holdings, Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2017	2016	2015
CURRENT ASSETS						
Cash and cash equivalents	$ 218,688	$ 4,580,641	$ -	$ 4,799,329	$ 4,976,536	$ 3,919,783
Receivables	5,567	21,742,767	-	21,748,334	19,529,233	19,140,754
Due from affiliates	1,860,598	-	(1,860,598)	-	-	-
Prepaid expenses and other current assets	590,327	769,691	-	1,360,018	1,522,083	1,646,839
Income taxes receivable	-	-	-	-	27,712	1,648
TOTAL CURRENT ASSETS	2,675,180	27,093,099	(1,860,598)	27,907,681	26,055,564	24,709,024
PROPERTY AND EQUIPMENT, net	1,097,872	3,363,420	-	4,461,292	5,049,508	4,099,992
DEFERRED INCOME TAXES	2,176,739	1,069,852	-	3,246,591	2,763,151	2,829,712
OTHER ASSETS	-	179,354	-	179,354	163,597	163,597
TOTAL ASSETS	$ 5,949,791	$ 31,705,725	$ (1,860,598)	$ 35,794,918	$ 34,031,820	$ 31,802,325

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES						
Accounts payable	$ 115,388	$ 1,851,563	$ -	$ 1,966,951	$ 2,789,532	$ 4,142,630
Accrued expenses	6,998,234	6,212,522	-	13,210,756	10,823,130	9,095,947
Income tax payable	-	110,131	-	110,131	34,000	981,949
Deferred revenues	-	2,299,145	-	2,299,145	3,069,719	3,987,199
Other current liabilities	-	2,152,486	-	2,152,486	1,772,095	1,772,095
Due to affiliates	-	1,860,598	(1,860,598)	-	-	-
TOTAL CURRENT LIABILITIES	7,113,622	14,486,445	(1,860,598)	19,739,469	18,488,476	19,979,820
DEFERRED RENT	-	1,514,144	-	1,514,144	1,695,264	1,747,097
NOTES PAYABLE - STOCKHOLDERS, less current portion	5,756,869	-	-	5,756,869	5,721,536	2,506,605
TOTAL LIABILITIES	12,870,491	16,000,589	(1,860,598)	27,010,482	25,905,276	24,233,522
COMMON STOCK	-	3,232	-	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	-	-	16,970	16,970	16,970
DEFERRED COMPENSATION EXPENSE	-	-	-	-	(461,980)	(841,980)
RETAINED EARNINGS (ACCUMULATED DEFICIT)	(6,937,670)	15,701,904	-	8,764,234	8,568,322	8,390,581
TOTAL STOCKHOLDERS' EQUITY (DEFICIT)	(6,920,700)	15,705,136	-	8,784,436	8,126,544	7,568,803
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 5,949,791	$ 31,705,725	$ (1,860,598)	$ 35,794,918	$ 34,031,820	$ 31,802,325

See Independent Auditors' Report

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARY

CONSOLIDATING STATEMENT OF INCOME AND RETAINED EARNINGS

Year Ended June 30, 2017

(with consolidated totals for the years ended June 30, 2016 and 2015)

	Health Services Holdings Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2017	2016	2015
SERVICE REVENUES						
Federal contracts	$ -	$ 71,064,634	$ -	$ 71,064,634	$ 61,193,167	$ 55,053,974
State and corporate contracts	-	24,282,179	-	24,282,179	23,369,481	23,323,387
TOTAL SERVICE REVENUES	-	95,346,813	-	95,346,813	84,562,648	78,377,361
DIRECT EXPENSES	-	58,831,488	-	58,831,488	52,593,968	50,774,860
GROSS MARGIN	-	36,515,325	-	36,515,325	31,968,680	27,602,501
ADMINISTRATIVE EXPENSES	1,263,151	34,448,351	-	35,711,502	31,498,630	27,159,385
INCOME (LOSS) FROM OPERATIONS	(1,263,151)	2,066,974	-	803,823	470,050	443,116
OTHER EXPENSE	(235,144)	(285,748)	-	(520,892)	(125,573)	(50,763)
INCOME (LOSS) BEFORE INCOME TAXES	(1,498,295)	1,781,226	-	282,931	344,477	392,353
INCOME TAXES						
Current provision	(19,933)	590,392	-	570,459	100,175	1,153,057
Deferred provision (benefit)	(537,794)	54,354	-	(483,440)	66,561	(999,021)
TOTAL INCOME TAXES	(557,727)	644,746	-	87,019	166,736	154,036
NET INCOME	(940,568)	1,136,480	-	195,912	177,741	238,317
RETAINED EARNINGS (DEFICIT), BEGINNING OF YEAR	(5,997,102)	14,565,424	-	8,568,322	8,390,581	8,152,264
RETAINED EARNINGS (DEFICIT), END OF YEAR	$ (6,937,670)	$ 15,701,904	$ -	$ 8,764,234	$ 8,568,322	$ 8,390,581

See Independent Auditors' Report

Attachment L

HSAG – 2016 Fiscal Year Financial Statements

As referenced in Section VI, 3.1.11.

HEALTH SERVICES HOLDINGS, INC.
AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
AND ADDITIONAL INFORMATION

Years Ended June 30, 2016, 2015 and 2014

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS AND ADDITIONAL INFORMATION

Years Ended June 30, 2016, 2015, and 2014

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholders of

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

We have audited the accompanying consolidated financial statements of ***Health Services Holdings, Inc. and Subsidiaries,*** which comprise the consolidated balance sheets as of June 30, 2016, 2015, and 2014, and the related consolidated statements of income and retained earnings, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of ***Health Services Holdings, Inc. and Subsidiaries*** as of June 30, 2016, 2015, and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Consolidating Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet as of June 30, 2016 and consolidating statement of income and retained earnings for the year ended June 30, 2016 are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements.

Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Mayer Hoffman McCann P.C.

Phoenix, Arizona
November 14, 2016

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

June 30, 2016, 2015, and 2014

ASSETS

	2016	2015	2014
CURRENT ASSETS			
Cash and cash equivalents	$ 4,976,536	$ 3,919,783	$ 1,553,668
Receivables	19,529,233	19,140,754	17,529,212
Prepaid expenses and other current assets	1,522,083	1,646,839	1,112,792
Income taxes receivable	27,712	1,648	50,474
Deferred income taxes	2,666,739	2,266,118	1,587,102
TOTAL CURRENT ASSETS	28,722,303	26,975,142	21,833,248
PROPERTY AND EQUIPMENT, net	5,049,508	4,099,992	3,683,649
DEFERRED INCOME TAXES	96,412	563,594	243,589
OTHER ASSETS	163,597	163,597	155,891
TOTAL ASSETS	$ 34,031,820	$ 31,802,325	$ 25,916,377

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES			
Accounts payable	$ 2,789,532	$ 4,142,630	$ 2,781,416
Accrued expenses	10,823,130	9,095,947	7,798,393
Income taxes payable	34,000	981,949	-
Deferred revenues	3,069,719	3,987,199	3,957,867
Other current liabilities	1,772,095	1,772,095	1,449,789
Current portion of capital lease obligation	-	-	89,166
TOTAL CURRENT LIABILITIES	18,488,476	19,979,820	16,076,631
DEFERRED RENT	1,695,264	1,747,097	1,429,061
NOTES PAYABLE - STOCKHOLDERS, less current portion	5,721,536	2,506,605	1,460,199
TOTAL LIABILITIES	25,905,276	24,233,522	18,965,891
COMMON STOCK, par value $1, authorized 1,000,000 shares, issued and outstanding 3,232 shares	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	16,970	16,970
DEFERRED COMPENSATION EXPENSE	(461,980)	(841,980)	(1,221,980)
RETAINED EARNINGS	8,568,322	8,390,581	8,152,264
TOTAL STOCKHOLDERS' EQUITY	8,126,544	7,568,803	6,950,486
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 34,031,820	$ 31,802,325	$ 25,916,377

See Notes to Consolidated Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME AND RETAINED EARNINGS

Years Ended June 30, 2016, 2015, and 2014

	2016	2015	2014
SERVICE REVENUES			
Federal contracts	$ 61,193,167	$ 55,053,974	$ 67,527,700
State and corporate contracts	23,369,481	23,323,387	20,171,093
TOTAL SERVICE REVENUES	84,562,648	78,377,361	87,698,793
DIRECT EXPENSES	52,593,968	50,774,860	59,394,959
GROSS MARGIN	31,968,680	27,602,501	28,303,834
ADMINISTRATIVE EXPENSES	31,498,630	27,159,385	28,336,539
INCOME (LOSS) FROM OPERATIONS	470,050	443,116	(32,705)
OTHER INCOME (EXPENSE)	(125,573)	(50,763)	353,544
INCOME BEFORE INCOME TAXES	344,477	392,353	320,839
INCOME TAXES			
Current provision	100,175	1,153,057	151,690
Deferred provision (benefit)	66,561	(999,021)	(213,120)
TOTAL INCOME TAXES	166,736	154,036	(61,430)
NET INCOME	177,741	238,317	382,269
RETAINED EARNINGS, BEGINNING OF YEAR	8,390,581	8,152,264	7,769,995
RETAINED EARNINGS, END OF YEAR	$ 8,568,322	$ 8,390,581	$ 8,152,264

See Notes to Consolidated Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended June 30, 2016, 2015, and 2014

	2016	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	$ 177,741	$ 238,317	$ 382,269
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	1,467,220	1,146,162	1,503,402
Change in deferred income taxes	66,561	(999,021)	(213,120)
Loss on disposition of fixed assets	1,616	123,115	11,609
Increase in notes payable - stockholders due to accrued interest	214,931	46,406	42,530
Changes in operating assets and liabilities:			
Decrease (increase) in:			
Receivables	(388,479)	(1,611,542)	(494,936)
Prepaid expenses and other current assets	124,756	(534,047)	37,670
Income taxes receivable	(26,064)	48,826	156,194
Increase (decrease) in:			
Accounts payable	(862,874)	488,464	(199,889)
Accrued expenses	1,727,183	2,279,503	2,037,920
Deferred revenues	(917,480)	29,332	1,056,313
Income taxes payable	(947,949)	-	-
Other current liabilities	-	322,306	(454,284)
Deferred rent	(51,833)	318,036	(487,599)
Net cash provided by operating activities	585,329	1,895,857	3,378,079
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchases of property and equipment	(2,908,576)	(812,870)	(1,256,079)
Change in other assets	-	(7,706)	-
Net cash used in investing activities	(2,908,576)	(820,576)	(1,256,079)
CASH FLOWS FROM FINANCING ACTIVITIES			
Net proceeds from (payments on) lines of credit	-	-	(1,625,000)
Payments on capital lease obligation	-	(89,166)	(236,966)
Payments on notes payable - stockholders	-	-	(842,695)
Proceeds on notes payable - stockholders	3,000,000	1,000,000	-
Change in deferred compensation expense	380,000	380,000	380,000
Net cash provided by (used in) financing activities	3,380,000	1,290,834	(2,324,661)
NET CHANGE IN CASH AND CASH EQUIVALENTS	1,056,753	2,366,115	(202,661)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	3,919,783	1,553,668	1,756,329
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 4,976,536	$ 3,919,783	$ 1,553,668
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid for interest	$ 7,574	$ 31,664	$ 118,334
Cash paid for income taxes	$ 1,077,997	$ 123,664	$ 7,316
SUPPLEMENTAL DISCLOSURE OF NON-CASH INVESTING AND FINANCING ACTIVITIES			
Increase in notes payable - stockholders due to accrued unpaid interest	$ 214,931	$ 46,406	$ 42,530
Purchases of property and equipment included in accounts payable	$ 382,526	$ 872,750	$ -

See Notes to Consolidated Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Years Ended June 30, 2016, 2015, and 2014

(1) Company operations and summary of significant accounting policies

Company operations - ***Health Services Holdings, Inc. and Subsidiaries*** (the "Company") is engaged in providing health care information in Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Louisiana, Maryland, Michigan, Nevada, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, U.S. Virgin Islands, Utah, Vermont, Virginia, Washington and Wyoming. Company efforts are designed to improve the quality of health care through the study of information.

The significant accounting policies followed by the Company are summarized below:

Principles of consolidation - The accompanying consolidated financial statements include the accounts of ***Health Services Holdings, Inc.*** ("HSH"), ***Health Services Advisory Group, Inc.*** ("HSAG"), ***Florida Medical Quality Assurance, Inc. dba FMQAI*** ("FMQAI"), and ***Health Services Advisory Group of California, Inc.*** ("HSAGCA"). In February 2004, HSH was established as a holding company of HSAG and FMQAI. The transactions to establish HSH resulted in the stockholders of HSAG becoming the majority stockholders of HSH. This transaction was accounted for under the rules applying to reverse acquisition accounting, under which HSAG's historical financial statement balances are carried forward as the financial reporting parent under the legal parent entity's name (HSH). As of July 1, 2014 and August 1, 2014, respectively, FMQAI and HSAG-CA were administratively dissolved. The operations of those entities that were required to continue were consolidated into and performed by HSAG. All significant intercompany transactions and accounts have been eliminated in consolidation.

Management's use of estimates - The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenue recognition - The Company recognizes revenue as services are performed. Cash received for future services is deferred until the service has been performed. The Company's contract with the Department of Health and Human Services is on a cost-plus-fee basis or cost only basis. Therefore, revenues for the contracts are recognized to the extent reimbursable costs are incurred and estimated fees are earned if applicable. Billings in excess of reimbursable costs incurred plus estimated fees are recorded as deferred revenue. Provisions for estimated losses on contracts are recognized in the period in which such losses are determined.

Costs related to certain contracts are subject to adjustment based on negotiations with, and the audits of the Company's records by its customers, including representatives of the federal government. Revenues for such contracts are recorded in amounts that are expected to be realized. It is reasonably possible that some portion of revenues recorded in the current period may be disallowed in future periods as a result of audits performed by the Company's customers. These disallowed revenues may be required to be refunded to the customer upon final settlement of the contract.

Cash and cash equivalents - Cash includes cash and, at times, cash equivalents which consist of highly liquid debt instruments purchased with original maturities of three months or less. Cash deposits are insured up to $250,000 by the Federal Deposit Insurance Corporation (FDIC).

(1) Company operations and summary of significant accounting policies (continued)

Receivables - Receivables are carried at the outstanding balances less an allowance for doubtful accounts. The Company evaluates the collectability of its receivables based on a combination of factors. In circumstances where it is aware of a specific customer's inability to meet its financial obligations, the Company records a specific reserve to reduce the amounts recorded to what is estimated to be collected. Accounts are charged off against the allowance when they are deemed to be uncollectible. Accounts receivable at June 30, 2016, 2015, and 2014 are considered by management to be collectible in full and, accordingly, an allowance for doubtful accounts is not necessary.

Depreciation and amortization - Depreciation and amortization is computed using straight-line and accelerated methods over the following estimated useful lives:

Furniture and equipment	3 - 10 years
Leasehold improvements	2 - 10 years
Equipment held under capital lease	5 years

Impairment of long-lived assets - The Company accounts for long-lived assets in accordance with the provisions of FASB ASC 360, *Property, Plant, and Equipment*, which requires that long-lived assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. No impairment charges were recorded for the years ended June 30, 2016, 2015, and 2014.

Deferred rent - Deferred rent represents the difference between the total rent payments amortized using the straight-line method over the life of the leases and the actual cash expenditures.

Income taxes - The Company follows FASB ASC 740, *Income Taxes*. FASB ASC 740 requires an asset and liability approach for financial accounting and reporting for income tax purposes. This statement recognizes (a) the amount of taxes payable or refundable for the current year, and (b) deferred tax liabilities and assets for future tax consequences of events that have been recognized in the financial statements or tax returns.

The Company accounts for uncertainty in income taxes through the application of a "more likely than not" threshold to the recognition and derecognition of uncertain tax positions. The provisions require that a change in judgment related to the expected ultimate resolution of uncertain tax positions be recognized in earnings in the year of such change. The Company's policy is to classify income tax penalties and interest as interest expense in its consolidated financial statements. At June 30, 2016, 2015, and 2014, the Company did not have any unrecognized tax benefits.

The Company files income tax returns in the U.S. federal jurisdiction and various state and local jurisdictions. The Company is no longer subject to U.S. federal and state and local income tax examinations by tax authorities for years before 2011.

(1) Company operations and summary of significant accounting policies (continued)

Fair value measurements - The Company currently has no assets or liabilities subject to fair value measurement other than at initial recognition.

Recently issued accounting pronouncements - The Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2014-09 – Revenue from Contracts with Customers (Topic 606) (ASU 2014-09) in May 2014, as amended, which is effective for nonpublic entities for annual reporting periods beginning after December 15, 2018. The FASB is currently undertaking efforts to provide implementation guidance to preparers of financial statements. The Company has not completed the process of evaluating the impact that will result from adopting ASU 2014-09 and is therefore unable to disclose the effects of adoption, if any, on the consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02 – *Leases (Topic 842)*. ASU 2016-02 requires that a lease liability and a related right-of-use asset representing the lessee's right to use or control the asset be recorded on the balance sheet upon the commencement of all leases except for short-term leases. Leases will be classified as either finance leases or operating leases, which are substantially similar to the classification criteria for distinguishing between capital leases and operating in existing lease accounting guidance. As a result, the effect of leases in the statement of operations and the statement of cash flows will be substantially unchanged from the existing lease accounting guidance. ASU 2016-02 is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted. The Company is currently evaluating the effect that the adoption of this standard will have on the consolidated financial statements.

Subsequent events - The Company has evaluated subsequent events through November 14, 2016, which is the date the consolidated financial statements were available to be issued.

(2) Receivables

Receivables consist of:

	2016	2015	2014
Contracts receivable:			
State and corporate contracts	$ 11,440,044	$ 9,376,315	$ 7,151,317
Federal contracts	8,013,680	9,761,339	10,377,045
Total contracts receivable	19,453,724	19,137,654	17,528,362
Other receivables	75,509	3,100	850
Total receivables	$ 19,529,233	$ 19,140,754	$ 17,529,212

The contracts receivable amounts above include billed and unbilled amounts as follows:

	2016	2015	2014
Billed	$ 16,487,076	$ 14,840,180	$ 15,299,323
Unbilled	1,719,061	3,201,603	2,179,039
Retainage	1,247,587	1,095,871	50,000
Total contracts receivable	$ 19,453,724	$ 19,137,654	$ 17,528,362

(3) Property and equipment

Property and equipment consists of:

	2016	2015	2014
Cost:			
Furniture and equipment	$ 9,879,861	$ 8,096,297	$ 7,361,527
Leasehold improvements	2,003,921	1,866,066	2,476,135
Equipment held under capital lease	-	-	748,147
Assets in process	215,365	73,070	53,980
Total cost	12,099,147	10,035,433	10,639,789
Accumulated depreciation and amortization	(7,049,639)	(5,935,441)	(6,956,140)
Net property and equipment	$ 5,049,508	$ 4,099,992	$ 3,683,649

Depreciation and amortization expense charged to operations was $1,467,220, $1,146,162, and $1,503,402, for the years ended June 30, 2016, 2015, and 2014, respectively.

Included in accumulated depreciation and amortization above is $0, $0, and $692,729, of accumulated amortization from equipment held under capital lease as of June 30, 2016, 2015, and 2014, respectively.

(4) Lines of credit

In May 2012, the Company entered into revolving lines of credit of $3,850,000, $1,150,000, and $1,150,000. All three lines of credit charged interest at LIBOR plus 2.75% (3.20%, 2.90%, and 2.95% at June 30, 2016, 2015 and 2014, respectively), or 4.25% if greater, payable monthly. The lines of credit matured in April 2015 and were replaced by an amended and restated revolving line of credit with a borrowing capacity of $6,150,000, maturing in February 2017. The amended line of credit bears an interest rate of LIBOR plus 2.50% and is secured by property and equipment, receivables and common stock of the Company. The line of credit is also guaranteed personally by certain stockholders of the Company. The lines of credit were subject to various financial and non-financial covenants. At June 30, 2016, there was $0 of borrowings outstanding on the lines of credit.

The Company had unexpired financial standby letters of credit through its bank at June 30, 2016, 2015, and 2014. The letters of credit expire annually, with automatic annual extensions unless notification is made 60 to 90 days in advance. The Company had standby letters of credit available of approximately $1,435,000 at June 30, 2016 and June 30, 2015 and $1,230,000 at June 30, 2014. The available balance to draw from the $6,150,000 revolving line of credit described above is reduced by these letters of credit.

(5) Notes payable - stockholders

During 2011, the Company borrowed $1,395,000 from the majority stockholder of the Company and signed a promissory note to the majority stockholder, in which unpaid principal accrues interest at 3% per annum, compound annually. During 2015, the Company borrowed an additional $1,000,000 and amended the promissory note such that unpaid principal accrues interest at 4% per annum. The note is unsecured and the outstanding principal and interest is due in June 2020. The outstanding principal and interest balance was $2,609,036, $2,506,605, and $1,460,199, at June 30, 2016, 2015, and 2014, respectively.

During 2011, the Company borrowed $40,000 from an immediate family member of the majority stockholder of the Company and signed a promissory note to the family member, in which unpaid principal accrued interest at 3% per annum, compound annually. The note is unsecured and the outstanding principal and interest was due in June 2016. During 2014, the loan balance was repaid in full.

(5) Notes payable – stockholders (continued)

During 2009, the Company borrowed $4,010,226 from a former majority stockholder of the Company and signed a promissory note, payable in five annual installments beginning December 30, 2009. The unpaid principal amount accrued interest at 2% per annum and the entire unpaid balance was due and payable on December 30, 2013. This note was secured by the assets of the Company. During 2014, the loan balance was repaid in full.

During 2016, the Company borrowed an additional $3,000,000 from the majority stockholder of the company and signed a promissory note to the majority stockholder, in which unpaid principal accrues at 5% per annum, compounded annually. The outstanding principal and interest balance was $3,112,500 at June 30, 2016. The note is unsecured and matures on March 30, 2020.

Annual maturities on the outstanding notes payable - stockholders are as follows:

Fiscal Year	
2017	$ -
2018	-
2019	-
2020	5,721,536
Total annual maturities	$ 5,721,536

Total interest expense recognized on these notes payable - stockholders was $214,931, $46,406, and $51,668, for the years ended June 30, 2016, 2015, and 2014, respectively.

(6) Other current liabilities

During the year ended June 30, 2003, HSAG purchased the stock of Florida Medical Quality Assurance, Inc. The stock transaction included a holdback of $537,000. During the year end June 30, 2005 this holdback was reduced to $470,302. During 2014, HSAG and the former owner of Florida Medical Quality Assurance, Inc. executed a release agreement which relieved HSAG from any future obligation with respect to the holdback. As such the liability was reversed, resulting in $470,302 of other income for the year ended June 30, 2014.

During the years ended June 30, 2007 through 2015, the Defense Contract Audit Agency ("DCAA"), working under directive from the Centers for Medicare and Medicaid Services ("CMS"), audited the costs charged to a CMS contract and recommended to CMS that certain costs be disallowed that were included in the general and administration cost pool as well as employee compensation costs. Included within these disallowed costs are certain costs relate to the final settlement of a lawsuit from one former executive and the partial settlement of a lawsuit from another executive. While CMS is not obligated to follow the recommendations of the DCAA, management has determined that CMS will disallow the costs.

(6) Other current liabilities (continued)

The liabilities recognized as a result of these matters consists of the following:

	2016	2015	2014
Disallowed costs related to legal settlements	$ 744,698	$ 744,698	$ 744,698
DCAA audit accrual for 2007 and 2008	140,497	140,497	140,497
DCAA audit accrual for 2008	331,804	331,804	331,804
DCAA audit accrual for 2010 and 2011	76,461	76,461	76,461
DCAA audit accrual for 2011	322,306	322,306	-
DCAA audit accrual for 2012	156,329	156,329	156,329
	$ 1,772,095	$ 1,772,095	$ 1,449,789

(7) Capital lease obligation

The Company entered into a non-cancelable capital lease agreement that expired in fiscal year 2015 for its copier and publication equipment. The Company also received a cash advance of approximately $107,000 as a lease incentive which was included in the fair value of the assets received as part of this capital lease. The lease matured in 2015 and the capital lease obligation was settled in full.

(8) Other income (expense)

	2016	2015	2014
Interest expense	$ (222,505)	$ (78,070)	$ (151,329)
Interest income	64,851	16,861	23,815
Other income (expense)	32,081	10,446	481,058
Total other income (expense)	$ (125,573)	$ (50,763)	$ 353,544

(9) Income taxes

Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred income taxes related primarily to differences between the financial and tax basis of property and equipment, deferred rent and certain accrued expenses, and the availability of net operating loss carryovers. The deferred taxes represent the future tax return consequences of these differences, which will either be taxable or deductible when the assets and liabilities are recovered or settled.

Deferred income tax assets are attributable to the following:

- State operating loss carryovers of approximately $58,000, $256,000, and $517,000 as of June 30, 2016, 2015, and 2014, respectively, provide future income tax benefits as they are applied against future state taxable income. The carryovers expire in various years from 2021 to 2023.

- Obligations for certain accrued expenses have no tax basis. Those accrued expenses will be deductible as payments are made in future periods.

- Expenses recorded for rents related to the deferred rent liability have no tax basis. The rent expense will be deductible as payments are made in future periods.

(9) Income taxes (continued)

Deferred income tax liabilities are attributable to the following:

- The basis of property and equipment for financial reporting exceeds its basis for tax purposes by the cumulative amount of the income tax depreciation and amortization over financial reporting depreciation and amortization. The excess will be taxable in future periods through reduced depreciation and amortization deductions for tax purposes.

The provision for income taxes consist of:

	2016	2015	2014
Current provision:			
Federal	$ 70,790	$ 973,545	$ 131,416
State	29,385	179,512	20,274
Total current provision	100,175	1,153,057	151,690
Deferred provision (benefit)			
Federal	64,024	(872,278)	(182,297)
State	2,537	(126,743)	(30,823)
Total deferred provision (benefit)	66,561	(999,021)	(213,120)
Total income taxes	$ 166,736	$ 154,036	$ (61,430)

The components of deferred tax assets and liabilities included in the accompanying consolidated balance sheets are as follows:

	2016	2015	2014
Current deferred income tax assets:			
Accrued expenses	$ 2,666,739	$ 2,266,118	$ 1,587,102
Noncurrent deferred income tax assets (liabilities):			
Property and equipment	(388,323)	(129,172)	(337,888)
Net operating loss carryovers	-	14,077	28,412
Accounts receivable retainage adjustment	(173,480)		
Deferred rent	658,215	678,689	553,065
Net noncurrent deferred income tax assets (liabilities)	$ 96,412	$ 563,594	$ 243,589

(9) Income taxes (continued)

The provision for federal income taxes differs from that computed by applying federal statutory rates to income before federal income tax expense, as indicated in the following analysis:

	2016	2015	2014
Federal statutory income tax at 34%	$ 117,122	$ 133,399	$ 110,127
Effect of state income taxes	11,559	14,536	10,120
Adjustments related to prior year true-ups	11,704	(1,936)	1,561
Effect of non-deductible meals, travel, and entertainment	20,192	15,284	12,835
State tax credit	-	(13,200)	-
Federal refund - prior year taxes	-	-	(13,874)
Reversal of book-only acquisition reserve	-	-	(183,417)
Other	6,159	5,953	1,218
Total provision for income taxes	$ 166,736	$ 154,036	$ (61,430)

(10) Employee benefit plans

The Company has a profit-sharing plan covering employees who meet specified age and service requirements. Contributions to the profit-sharing plan are determined annually at the discretion of the Company's Board of Directors. The matching contributions made by the Company were $644,671, $647,045, and $660,448, for the years ended June 30, 2016, 2015, and 2014, respectively.

The Company has an employee stock ownership plan (ESOP) covering employees who meet specified age and service requirements. Contributions are determined annually at the discretion of the Company's Board of Directors.

Effective December 31, 2008, the Health Services Holdings, Inc. Employee Stock Ownership Plan (ESOP) became a leveraged plan. The purchase was structured with a blend of cash and debt. To facilitate the sale, HSH loaned the ESOP $3,800,000 and a stockholder loaned the ESOP $539,773. The ESOP shares were pledged as collateral on the aggregate amount borrowed of $4,339,773, which was initially recorded as deferred compensation expense in the accompanying consolidated balance sheets. As debt is repaid to HSH and the stockholder, shares are released from collateral and allocated to active employees, based on their compensation. The Company funds the ESOP through contributions authorized by the Company. At a minimum, the Company intends to contribute amounts equal to the annual principal due on the debt. The Company made contributions to the ESOP of $1,523,354, $1,457,427, and $1,517,416, for the years ended June 30, 2016, 2015, and 2014, respectively.

At June 30, 2016, 912.84 shares held by the ESOP have been released or committed to be released to the plan's participants. The participants have a limited put option right to the Company that would require the Company to repurchase its common stock from participants in the ESOP who are eligible to receive benefits under the terms of the plan and elect to receive cash for their common stock. The potential commitment for the put option at June 30, 2016 is approximately $9,700,000.

The ESOP stock share information as of June 30, 2016 is as follows:

Allocated shares	912.84
Unreleased shares	57.16
Total ESOP shares	970

(11) Leases

The Company leases office space and equipment under operating leases expiring in various years through fiscal year 2025. Minimum future rental payments under noncancellable operating leases having remaining terms in excess of one year including leases entered into by the Company through the date of this report are as follows:

Years Ending June 30,	
2017	$ 3,265,657
2018	3,334,290
2019	3,330,892
2020	3,345,760
2021	1,198,267
Thereafter	2,642,672
Total minimum future rental payments	$ 17,117,538

Total rental expense under operating leases with terms in excess of one month was $3,159,805, $3,496,600, and $3,033,161, for the years ended June 30, 2016, 2015, and 2014, respectively.

Some of the operating leases above contain renewal options while others make no provision for renewal options. In the normal course of business the Company will either renew leases or seek other arrangements.

(12) Concentrations

The Company generates a substantial portion of its revenues from contracts with the federal government. The Company is the sole provider of Quality Improvement Network (QIN) review services in Arizona, Florida California, Ohio, and the U.S. Virgin Islands under specific contracts with the federal government's Centers for Medicare and Medicaid Services (CMS). In addition, the Company holds several contracts with CMS, or a subcontractor to CMS.

During the years ended June 30, 2016, 2015, and 2014 revenues from contracts with CMS were $61,193,167, $54,769,250, and $66,800,875, respectively. Amounts due from CMS contracts included in receivables were $8,013,680, $9,761,339, and $10,388,524 as of June 30, 2016, 2015, and 2014, respectively.

If the Company were unable to maintain current or future contracts, the Company's operations could be substantially affected.

(13) Commitments and contingencies

All of the Company's assets and stock are pledged as collateral on certain debt arrangements held by the Company.

Contract revenue received on government contracts is subject to future audits and adjustments by government audit agencies. Any disallowed costs, including amounts already collected, may constitute a liability of the Company. The amount of costs and related revenue that may be disallowed by future government audits cannot be determined at this time. However, the Company expects such amounts, if any, to be immaterial.

ADDITIONAL INFORMATION

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET

June 30, 2016
(with consolidated totals for June 30, 2015, and 2014)

ASSETS

	Health Services Holdings, Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2016	2015	2014
CURRENT ASSETS						
Cash and cash equivalents	$ 147,526	$ 4,829,010	$ -	$ 4,976,536	$ 3,919,783	$ 1,553,668
Receivables	3,950	19,525,283	-	19,529,233	19,140,754	17,529,212
Due from affiliates	1,574,099	-	(1,574,099)	-	-	-
Prepaid expenses and other current assets	505,648	1,016,435	-	1,522,083	1,646,839	1,112,792
Income taxes receivable	14,182	13,530	-	27,712	1,648	50,474
Deferred income taxes	1,758,423	908,316	-	2,666,739	2,266,118	1,587,102
TOTAL CURRENT ASSETS	4,003,828	26,292,574	(1,574,099)	28,722,303	26,975,142	21,833,248
PROPERTY AND EQUIPMENT, net	1,042,237	4,007,271	-	5,049,508	4,099,992	3,683,649
DEFERRED INCOME TAXES	(119,478)	215,890	-	96,412	563,594	243,589
OTHER ASSETS	-	163,597	-	163,597	163,597	155,891
TOTAL ASSETS	$ 4,926,587	$ 30,679,332	$ (1,574,099)	$ 34,031,820	$ 31,802,325	$ 25,916,377

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES						
Accounts payable	$ 409,920	$ 2,379,612	$ -	$ 2,789,532	$ 4,142,630	$ 2,781,416
Accrued expenses	5,237,243	5,585,887	-	10,823,130	9,095,947	7,798,393
Income tax payable	-	34,000	-	34,000	981,949	-
Deferred revenues	-	3,069,719	-	3,069,719	3,987,199	3,957,867
Other current liabilities	-	1,772,095	-	1,772,095	1,772,095	1,449,789
Current portion of capital lease obligation	-	-	-	-	-	89,166
Due to affiliates	-	1,574,099	(1,574,099)	-	-	-
TOTAL CURRENT LIABILITIES	5,647,163	14,415,412	(1,574,099)	18,488,476	19,979,820	16,076,631
DEFERRED RENT	-	1,695,264	-	1,695,264	1,747,097	1,429,061
NOTES PAYABLE - STOCKHOLDERS, less current portion	5,721,536	-	-	5,721,536	2,506,605	1,460,199
TOTAL LIABILITIES	11,368,699	16,110,676	(1,574,099)	25,905,276	24,233,522	18,965,891
COMMON STOCK	-	3,232	-	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	-	-	16,970	16,970	16,970
DEFERRED COMPENSATION EXPENSE	(461,980)	-	-	(461,980)	(841,980)	(1,221,980)
RETAINED EARNINGS (ACCUMULATED DEFICIT)	(5,997,102)	14,565,424	-	8,568,322	8,390,581	8,152,264
TOTAL STOCKHOLDERS' EQUITY (DEFICIT)	(6,442,112)	14,568,656	-	8,126,544	7,568,803	6,950,486
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 4,926,587	$ 30,679,332	$ (1,574,099)	$ 34,031,820	$ 31,802,325	$ 25,916,377

See Independent Auditors' Report

HEALTH SERVICES HOLDINGS, INC. AND SUBSIDIARIES

CONSOLIDATING STATEMENT OF INCOME AND RETAINED EARNINGS

Year Ended June 30, 2016

(with consolidated totals for the years ended June 30, 2015 and 2014)

	Health Services Holdings Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2016	2015	2014
SERVICE REVENUES						
Federal contracts	$ -	$ 61,193,167	$ -	$ 61,193,167	$ 55,053,974	$ 67,527,700
State and corporate contracts	-	23,369,481	-	23,369,481	23,323,387	20,171,093
TOTAL SERVICE REVENUES	-	84,562,648	-	84,562,648	78,377,361	87,698,793
DIRECT EXPENSES	-	52,593,968	-	52,593,968	50,774,860	59,394,959
GROSS MARGIN	-	31,968,680	-	31,968,680	27,602,501	28,303,834
ADMINISTRATIVE EXPENSES	1,157,619	30,341,011	-	31,498,630	27,159,385	28,336,539
INCOME (LOSS) FROM OPERATIONS	(1,157,619)	1,627,669	-	470,050	443,116	(32,705)
OTHER INCOME (EXPENSE)	(200,069)	74,496	-	(125,573)	(50,763)	353,544
INCOME (LOSS) BEFORE INCOME TAXES	(1,357,688)	1,702,165	-	344,477	392,353	320,839
INCOME TAXES						
Current provision	(102,135)	202,310	-	100,175	1,153,057	151,690
Deferred provision (benefit)	(338,753)	405,314	-	66,561	(999,021)	(213,120)
TOTAL INCOME TAXES	(440,888)	607,624	-	166,736	154,036	(61,430)
NET INCOME	(916,800)	1,094,541	-	177,741	238,317	382,269
RETAINED EARNINGS (DEFICIT), BEGINNING OF YEAR	(5,080,302)	13,470,883	-	8,390,581	8,152,264	7,769,995
RETAINED EARNINGS (DEFICIT), END OF YEAR	$ (5,997,102)	$ 14,565,424	$ -	$ 8,568,322	$ 8,390,581	$ 8,152,264

See Independent Auditors' Report