# NEBRASKA

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## DEPT. OF HEALTH AND HUMAN SERVICES

**State of Nebraska**
**Department of Health and Human Services**
**Division of Medicaid and Long-Term Care**

**Quality Strategy for Heritage Health**
**Program**
**2023**

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# 1. Introduction

## Managed Care in Nebraska

The Nebraska Medicaid Managed Care Program, Heritage Health, combines Nebraska Medicaid and Long-Term Care (MLTC)'s physical health, behavioral health, dental, and pharmacy programs into a single comprehensive and coordinated program for the state's Medicaid and Children's Health Insurance Program (CHIP) enrollees. Formerly referred to as the Nebraska Health Connection (NHC), managed care was implemented in July 1995 with two separate 1915(b) waivers: one for physical health and one for mental health and substance use disorders (SUDs), with full-risk behavioral health managed care effective September 2013. Beginning January 1, 2017, Nebraska implemented the Heritage Health program and contracted with three Managed Care Organizations (MCOs) to deliver Medicaid services statewide. Notable changes associated with the implementation of this program include the integration of physical and behavioral health care,  and inclusion of pharmacy services in the core benefit package and the MCOs capitation rate; inclusion of the aged, blind and disabled (ABD) populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services; and the expansion of enrollment broker services to complete the process of member enrollment.

Another program implemented in 2017 transitioned Nebraska's fee-for-service (FFS) dental program into a managed care delivery system. The dental benefits manager (DBM) is a prepaid ambulatory health plan (PAHP) that contracts with MLTC for the delivery of Medicaid dental benefits and services. This report refers to the MCOs and the DBM combined as the Managed Care Entities (MCEs).

In 2018, Nebraska's voters approved Medicaid Expansion, and on October 1st, 2020, Medicaid coverage was expanded to otherwise ineligible adults with incomes up to 138% of the federal poverty level, under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Beginning July 2019, non-emergency medical transportation (NEMT) services were carved into the Heritage Health Program, thereby allowing the MCOs to further integrate and coordinate care for their members.

In 2022 the Nebraska Department of Health and Human Service (DHHS) issued a request for proposals (RFP) to select qualified bidders for the Heritage Health contracts. The new RFP includes several changes: integrating dental services with physical health, behavioral health, and pharmacy services, simplifying credentialing for providers, and improving electronic visit verification. The RFP also requires the MCOs to have a highly integrated dual eligible dual special needs plan (HIDE DSNP) in place in order to serve members who are eligible for both Medicare and Medicaid under a single MCO. Two incumbent MCOs were selected, along with one new contractor. Beginning on January 1, 2024, the Heritage Health program will include MCOs Molina, Nebraska Total Care and United Healthcare Community Plan, which will serve all Medicaid and CHIP enrollees statewide under 1915(b) authority. Table 1 below shows Nebraska MCEs through December 31, 2023.

Table 1: Nebraska MCEs

| Entity Name | MCE Type | Managed Care Authority | Populations Served |
|---|---|---|---|
| Healthy Blue (HB) | MCO | 1915(b) | Medicaid and CHIP enrollees, statewide |
| Nebraska Total Care (NTC) | MCO | 1915(b) | Medicaid and CHIP enrollees, statewide |
| United Healthcare Community Plan (UHCCP) | MCO | 1915(b) | Medicaid and CHIP enrollees, statewide |
| Managed Care of North America (MCNA) | PAHP | 1915(b) | Dental coverage for Medicaid and CHIP enrollees, statewide |

## Quality Management Structure

The Heritage Health program is overseen by MLTC. The Medicaid Plan Management team, in collaboration with all other branches of MLTC and the Medicaid Medical Services Director, is responsible for the development, implementation and evaluation of the Medicaid Managed Care Quality Strategy.

## MCE Quality Assessment and Performance Improvement (QAPI) Program

MLTC requires MCEs to have an ongoing QAPI program for the services it furnishes to its enrollees. The QAPI program includes processes to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The program includes goals, objectives, and accountability for quality management processes and supports and complies with MLTC's Quality Strategy.

The MCE's QAPI program, at a minimum, must comply with state and federal requirements (including 42 CRF 438.330) and utilization management (UM) program requirements described in 42 Code of Federal Regulations (CFR) 456. The QAPI program must:

- ensure continuous evaluation of the MCE's operations. The MCEs must be able to incorporate relevant variables and targets as defined by MLTC;
- at a minimum, assess the quality and appropriateness of care furnished to members (including those with special health care needs);
- provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician;
- maintain a health information system (HIS) that can support the QAPI program; the MCE's HIS must support the QAPI process by collecting, analyzing, integrating, and reporting data required by MLTC's Quality Strategy. All collected data must be available to the MCEs and MLTC;
- make available to its members and providers information about the QAPI program and a report on the MCE's progress in meeting its goals annually; this information must be submitted for review and approval by MLTC prior to distribution;
- solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance. The MCEs must further develop, operationalize, and implement the outcome and quality performance measures with the QAPI Committee, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders; and

- require that the MCEs make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCEs and any additional quality management (QM) reviews; this may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.

## Nebraska Medical Care Advisory Committee

In accordance with 42 CFR 431.12, MLTC has established a Medical Care Advisory Committee (MCAC). Additionally, Nebraska State law, Neb Rev Stat 68-906, adopts these federal provisions as a matter of state law. Article III Section 1 of the MCAC bylaws state:

The purpose of the MCAC is:

(a) to formulate and recommend policies, analyze and recommend changes in programs, and review services provided to recipients.

(b) to interpret stakeholder opinions and needs regarding services.

(c) to provide a two-way channel of communication among the individuals, organizations, and facilities in Nebraska interested in care and services.

(d) to review health plan marketing materials, including but not limited to member handbooks and member information letters and notices.

(e) to facilitate the representative process, create public understanding, and ensure that services meet the needs of Nebraskans served at a reasonable cost to the taxpayers; and

(f) to review or act in accordance with any other applicable law or directive.

Members of the MCAC are appointed by the Medicaid Director. Membership is interdisciplinary and is to include members who are familiar with quality improvement and the medical needs of Nebraska Medicaid beneficiaries. Membership is to include Medicaid beneficiaries or advocates of beneficiaries; medical providers including at least one person from physical health, behavioral health, pharmacy and long term/chronic care provider types; and DHHS Directors from the divisions of MLTC, Children and Family Services (CFS), Developmental Disabilities (DD) and Behavioral Health (DBH).

The MCAC is an advisory committee. Specifically, the MCAC may advise and make recommendations regarding Nebraska Medicaid. The committee has the opportunity to participate in policy development and program administration; however, the MCAC is not a policymaking body. Information about this committee is available publicly, and their meeting minutes can be reviewed here: https://dhhs.ne.gov/Pages/MCAC.aspx

## Goals and Objectives

The goals and objectives for the Heritage Health Program, described in Table 2, directly reflect the Quadruple Aim of improving member experience of care, provider experience, the health of populations, and ensuring the long-term financial viability of the Medicaid program.

Table 2: Goals and Objectives of Heritage Health Program

| Aim | Goal | Objective |
|---|---|---|
| Improve the Member Experience of Care | Enhance integration of services and whole person care | Integrate dental care into Heritage Health contracts |
| | | Update NEMT Regulations to allow for additional transportation flexibility |
| | Expand access to high-quality services to meet the needs of diverse clients | Update telehealth regulations to improve access to care |
| | | Ensure timely access to primary and specialty care |
| | Improve coordination of care | Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management |
| | Increase member satisfaction | Engage with enrollees to improve enrollee experience and outcomes and increase public awareness about services |
| Improve the Provider Experience of Care | Timely decision making | Ensure timely payment for claims |
| | | Resolve appeals in a timely manner |
| | Increase provider satisfaction | Streamline provider credentialling by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialling verification subcontractor |
| | Build transparent and trusting stakeholder relationships | Conduct regular "listening sessions" where relevant MLTC leadership meet with provider and community constituents at least quarterly to solicit their ideas, suggestions, and feedback for incorporation into policies and program improvements when/where possible. |
| Improve the Health of Populations | Promote wellness and prevention | Improve screening rates for cancers |
| | | Promote oral health |
| | | Ensure access to care during pregnancy, childbirth and postpartum |
| | | Promote healthy development and wellness in children and adolescents |
| | | Improve immunization rates |
| | | Ensure appropriate use of prescription drugs |
| | Improve Chronic disease management and control | Improve hypertension, diabetes, and cardiovascular disease management and control |

| | | Improve access to mental health and substance use disorder care |
|---|---|---|
| | Identify and implement initiatives to close care gaps and address health disparities for underserved communities. | Advance interventions which address social determinants of health |
| | | Identify enrollees who are experiencing homelessness and provide care coordination and case management |
| | | Identify potential enrollees who are transitioning from incarceration and provide support through the eligibility process and their reentry into the community |
| Reduce the Per Capita Cost of Healthcare | Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions | Reduce the number of emergency department visits for substance use disorders. |
| | | Increase the percentage of adults who initiate and continue treatment after a diagnosis of alcohol or other drug abuse/dependence. |
| | | Improve maternal health and reduce the pre-term birth rate in Medicaid beneficiaries. |
| | Pay for value and incentivize innovation | Incorporate into Heritage Health contracts incentives for improving health outcomes. |

To support these goals and objectives MLTC has developed a series of performance measures that will be monitored in order to evaluate the effectiveness of MLTC's Quality Strategy. These quality measures can be found in Appendix A: MCE Performance Measures.

## 2. Quality of Care

MLTC has implemented systems for the ongoing assessment of the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCE's contracts. These systems enable MLTC to monitor data related to the access of Medicaid enrollees to comprehensive and cost-effective health services. This includes evidence-based care options that emphasize early intervention and community-based treatment as well as reducing rates of costly and avoidable emergency and inpatient hospital levels of care. Through the implementation of these assessment systems, MLTC can monitor trends, demonstrate successes, and identify challenges in achieving the objectives of this Quality Strategy. MLTC expects the MCEs to evaluate the effectiveness of their program interventions and continuously adjust them in order to support improved health outcomes for enrollees.

### National Quality Metrics

The MCOs report on the CMS Adult Core Set, CMS Child Core Set, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, and Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as well as additional performance measures as determined by MLTC. The DBM reports on performance measures determined by MLTC, which may include HEDIS measures, CMS measures, and Dental Quality Alliance (DQA) measures. The MCEs report using the most current version, specification, or manual available prior to required reporting deadlines, as is related to the given measure set.

The MCEs must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCE that does not show statistically significant improvement in a measure rate. MLTC may require the MCE to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCE that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.

For the contracted MCOs beginning on January 1, 2024, there will be additional contract requirements which are tied to performance measures. The MCO must use quality improvement activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers. They will also be required to use quality improvement activities and initiatives to identify disparities in health care access, service provision, satisfaction, and outcomes. This includes obtaining data on member demographics and social determinants, stratifying MCO data such as claims, HEDIS measures, CAHPS, health risk assessment (HRS), member-identified race, ethnicity, geography, language, and social determinants of health (SDOH) to determine populations with the highest needs.

MCEs are required to attain NCQA accreditation. Standardized accreditation combined with the integration of physical and behavioral health programs, allows MLTC to better evaluate quality performance and provides for a clearer comparison between MCOs.

## Public Posting of Quality Measures and Performance Outcomes

DHHS has a public website, which includes pages dedicated to information about MLTC: https://dhhs.ne.gov/Pages/Medicaid-and-Long-Term-Care.aspx . All DHHS pages can be immediately translated into 32 languages to ensure information is accessible to all beneficiaries.

MLTC maintains a public dashboard which is updated annually and shows select outreach and health outcomes for each MCO, found here https://dhhs.ne.gov/Pages/Heritage-Health-Dashboard.aspx.  The metrics are available in graphic and data format, and are the following metrics:

- Enrollment
- Total claims paid
- Quarterly medical and administrative expenses (dollars)
- Average member call length
- Average member hold time
- Average provider call length
- Average provider call hold time
- Number of MCO member outreach events
- Number of MCO provider outreach events
- Tdap Vaccinations in pregnant women
- Percentage of 15-month-olds with 6 or more well child visits

Annually, MLTC posts publicly the final aggregated EQR report, found on the DHHS Heritage Health Resources website under Reports and Surveys, External Quality Review: https://dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx

Within the 2022-2023 EQR report, the measures and outcomes listed are:

- Validation of PIPs (page 2-1)
- Validation of Performance Measures
    - Information Systems Standards Review (page 2-2)
    - CMS Adult and Child Core Measures (page 2-5)
    - HEDIS Measures (page 2-6)
- Assessment of Compliance with Medicaid Managed Care Regulations (page 2-19)
- Validation of Network Adequacy (page 2-21)
- Evaluation of Nebraska's Managed Care Quality Strategy (page 2-30)

## Performance Improvement Projects (PIP) and PIP Interventions

MLTC requires the MCEs to undertake projects to continually improve the quality, access and timeliness of care provided to its members. The MCEs conduct Performance Improvement Projects, which require a concerted effort to improve a particular problem, condition or system-wide concern. PIPs involve gathering information systematically to identify the issues and barriers impeding their resolution, as well as involve the planning and implementation of interventions to address these issues.

Each MCE must conduct at least one PIP that focuses on clinical indicators and another that focuses on non-clinical indicators. As an alternative the MCEs may conduct one PIP consisting of both clinical and

non-clinical performance indicator measures. The clinical topic must address a relevant topic to the MCE's population, which is expected to have a favorable effect on health outcomes. The non-clinical measure should address member satisfaction or corresponding process associated with the clinical measure. PIPs must meet all relevant CMS requirements and be approved by MLTC or its designee prior to implementation. Furthermore, CMS may specify a PIP topic, which must be included in the PIPs required by MLTC.

Nebraska's contracted external quality review organization (EQRO) Health Services Advisory Group (HSAG) facilitates meetings with MCEs to provide technical guidance in the development and execution of PIPs. Annually the EQRO also validates MCE's PIPs and related performance measures in accordance with 42 CFR 438.330(b)1) and produces a report, reviewed and approved by MLTC. The report summarizes the PIP results and findings for each MCE and recommendations for improvement.

See Appendix B: MCO PIP Aims and Interventions and Appendix C DBM PIP Aims and Interventions for NE PIP aims and interventions from 2018- 2022. The PIPs carried out by the contracted MCEs have been a direct reflection of the overall goals for improving the quality of managed care in Nebraska.

## Other Quality Interventions

### Value-Based Purchasing Initiatives

The Heritage Health Program has been designed to promote greater collaboration between MCOs and providers by encouraging more sophisticated strategies for purchasing health care services. Value-based purchasing (VBP) requirements promote added value for members and providers by aligning the financial goals of the MCOs and the provider. MLTC defines value-based contracts as payment and contractual arrangements between the MCOs and providers that include:

- • accountability for improvements in health outcomes, care quality, or cost efficiency; and
- • payment methodologies that align providers' financial and contractual incentives with those of the MCOs.

Since the initiation of the Heritage Health program and the requirements that MCOs enter into VBP arrangements with a growing population of their contracted providers, MLTC has witnessed an alignment of these arrangements with the goals and objectives of this Quality Strategy. MCOs have all experienced success at varying levels in their respective value based contracting arrangements. The create partnerships with provider groups with the goal of adding value to care for both members and providers, expanding access to care, and closing gaps in quality metrics.

The following are examples of metrics which are being targeted for gap closures through the value-based contracting arrangements made by MLTC's contracted MCOs, aligning with MLTC's Quality Strategy:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- Immunizations for Adolescents
- Prenatal and Postpartum Care
- Follow-Up After Hospitalization for Mental Illness

## Quality Performance Program

The MCEs participate in the MLTC Quality Performance Program (QPP), which is implemented in accordance with Neb. Rev. Stat. §68-995 and any successor statutes. Neb. Rev. Stat. §68-995 is provided as Appendix D: Neb. Rev. Stat. §68-995. Pursuant to this statute, the MCEs must hold back 1.5% of at-risk capitation revenue received by the MCEs and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the MCEs to earn via the QPP. QPP measures for which the MCOs are eligible to earn hold-back funds are included in Appendix E: Heritage Health MCO Quality Performance Program Measures. QPP measures for which the DBM is eligible to earn hold-back funds are included in Appendix F: DBM Quality Performance Program Measures.

The MCEs must report its performance measures that affect the MCE's eligibility to earn hold-back funds monthly, quarterly, semi-annually (DBM only), annually, and upon the request of MLTC. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC assesses the MCE's performance based on the measures annually and notifies the MCEs of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC makes this determination within 12 months after the end of each performance year. All earned hold-back funds become the property of the MCEs. The MCEs must deposit unearned (forfeited) hold- back funds to MLTC. MLTC reimburses the federal share of the forfeited funds to CMS, and the remaining state share of the forfeited hold-back funds is retained by MLTC. No interest is due to either party on hold-back funds retained by the MCEs or returned to MLTC.

MLTC reserves the right to modify annually the measures and criteria for earning the hold-back funds. These include operational or administrative measures that reflect MCEs business processes and may lead to improved access to and quality of care, CMS Medicaid adult and child core measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement as indicated by Heritage Health historical performance.

## University of Nebraska Medical Center (UNMC) Directed Payments

MLTC utilizes the opportunity provided in 42 CFR § 438.6(c) through two Section 438.6(c) preprints which allow for directed payments to the University of Nebraska Medical Center (UNMC). These preprints are utilized in order to increase access to quality and timely services; one for dental services and the other for access to specialists in rural areas of the state which UNMC serves.

These payment arrangements increase training opportunities for medical students, as well as incentivize providers to work in underserved areas of the state. These financial interventions have a direct impact on the Medicaid member's ability to obtain high quality care in a timely manner.

## 1115 SUD Waiver

MLTC's Substance Use Disorder (SUD) demonstration waiver began on July 1, 2019 and it allows Nebraska Medicaid to cover SUD residential services in Institutions for Mental Diseases (IMDs) for Medicaid-enrolled adults ages 21-64. Coverage of residential services allows Medicaid enrollees to receive the appropriate level of care, reducing emergency department visits and increasing referrals for outpatient community-based services upon discharge. This waiver also supports MLTC's efforts to implement models of care focused on increasing support for individuals in the community and home,

outside of institutions, and improve access to a continuum of SUD evidence-based services at varied levels of intensity.

## State Regulation Updates

During the federal COVID-19 public health emergency (PHE) MLTC implemented many temporary flexibilities which expanded access to services. With the end of the PHE many of the temporary flexibilities ended, but MLTC is updating state regulations in order to allow for some of the flexibilities to continue post PHE.

Though Nebraska Medicaid has been a leader in the availability of telehealth coverage for many years, the PHE expanded the actual use of telehealth significantly. Nebraska is a highly rural state and so use of telehealth for the delivery of care has the ability to have a positive impact on access to services. MLTC is utilizing the knowledge and experience gained throughout the PHE to guide the updates being made to these regulations so that they will ensure patient safety and clinically appropriate use.

MLTC has also recognized the need for updates to the regulations guiding NEMT services so that they improve the quality and member experience of this service, and better match the way this service is now being utilized.

## Transition of Care Policy

MLTC requires each MCO to establish a process to ensure continuity of care for a member. The MCOs must establish an automated process for the transitioning of a member's previously approved authorizations and care management plans to the newly assigned MCO.

All MCO enrollments are managed by a contracted enrollment broker. The enrollment broker notifies each MCO of eligible individuals who are enrolled, re-enrolled or disenrolled from the MCO for the following month through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction. The enrollment broker's MCO auto assignment algorithm methodology takes into consideration a member's chosen primary care provider (PCP). If the current PCP is not in network the enrollment broker will use a round robin method to determine an MCO assignment which maximizes the preservation of existing provider relationships.

The MCOs are required to provide active assistance to members when transitioning to another Heritage Health MCO or to Medicaid FFS. The receiving MCO is responsible to provide medically necessary services covered under the contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.) of thirty (30) calendar days for medical and behavioral health services, and ninety (90) calendar days for pharmacy services. During this transition period the receiving MCO is responsible for notification to the new PCP of the member's selection, initiation of the request for transfer of the member's medical files, arrangement of medically necessary services (if applicable), all other requirements for new members, and any other actions necessary for the transition of care. For all transplants, all previous coverage authorizations are honored, without redetermination during the transition periods unless the end date on the coverage authorization is prior to the expiration of the transition period.

In order to operationalize these required actions, MLTC's contracted MCOs have collaborated to develop a process flow which assures continuity of care. The process creates an open dialog between the MCOs, including technical connection via a secure file transfer portal (SFTP). When the transition from one MCO to another occurs, the supplying MCO will provide to the receiving MCO information related to any open authorizations and approved medications through the SFTP. The receiving MCO will leverage the supplied information to trigger their process for initiating care management participation.

## Plan of Care for the Disabled or Medically Complex

Nebraska, 477 NAC 27.002.02(C)(ii)(1) defines disability as follows: "Generally, an individual is disabled if the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A child through 17 years old is considered disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity. See Titles II and XVI of the federal Social Security Act, as amended, for further disability criteria. The Social Security Administration has the primary responsibility of determining whether an individual meets the disability criteria." Medicaid applicants are evaluated on these criteria during the eligibility determination process.

When any individual is found eligible for Medicaid, whether due to disability or for other qualifying reasons, their assigned MCO is provided with information detailing the demographics which were provided by the new enrollee during the eligibility assessment process, such as age, race, ethnicity, sex, primary language and disability status. The MCO must accept all eligible individuals who select it as their health plan or are assigned to it, and must not discriminate against MCO members on the basis of their health history, health status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, ethnicity or language needs.

The assigned MCO is required to provide each new enrollee a health risk screening (HRS), which is used to identify members in need of the MCO care management services.

The HRS includes a set of MLTC developed questions about physical health, behavioral health, and Social Determinants of Health (SDoH). SDoH questions are designed to assess a member's economic stability, housing stability, food security, education and job opportunities, intimate partner violence, community and social support, and access to health care. The physical health and behavioral health questions are designed to assess a member's health status.

Members may be identified for care and case management through the HRS, along with analysis and evaluation of historical claims data performed by the MCOs, provider referrals, homeless attestations, or self-identification by the beneficiary. Assessments should collect information such as:

- Severity of the member's health conditions/disease state;
- Co-morbidities, or multiple complex health care conditions;
- Recent treatment history and current medications;
- Long-term services and supports the member currently receives;
- Demographic and social determinants of health information (including ethnicity, education, living situation/housing, legal status, employment status, food security);

- Activities of daily living (including bathing, dressing, toileting, mobility, and eating);
- Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation);
- Communication and cognition;
- Indirect supports;
- General health and life goals;
- Safety (need for welfare/protection to eliminate harm to self or others);
- The member's current treatment providers and care plan, if applicable;
- Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma;
- Substance use, including alcohol; and
- Interest in receiving care and case management services

Through assessments the MCO must identify any members that they determine to be medically complex. For an individual to be determined medically complex, he or she must have a documented medical condition identified through analysis and evaluation performed by the MCO, or identified through information supplied by MLTC, that falls into one or more of the following categories:

- A disabling mental disorder;
- A chronic substance abuse disorder;
- A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs (see 471 NAC 12 for the definition of activities of daily living for adults);
- A disability determination based on Social Security criteria;
- A serious and complex medical condition; or
- Chronically homeless.

An additional intervention being implemented by MLTC in order to identify Medicaid members who are experiencing homelessness is through a data-sharing agreement with Nebraska's Continuum of Care (CoC) system. This system is funded by the Nebraska Homeless Assistance Program (NHAP), a grant program which funds organizations that provide services to people who are at-risk for or experiencing homelessness. Through this data sharing agreement, Medicaid enrollees who contact one of the many locations affiliated with the CoC across the state will be directly referred to their MCO for additional care management and supports.

Through the identification of individuals who may have barriers to care or who may need enhanced care in order to meet their health care needs, Nebraska Medicaid beneficiaries are able to access support systems through the MCOs care management programs. Nebraska does not provide LTSS through managed care, though through the MCO's assessment process individuals who have special health care needs or need LTSS can be identified and receive assistance from the MCO's care and case management services.

## 3. Monitoring and Compliance

### Network Adequacy and Availability of Services

MLTC stipulates through its contracts with the MCEs the expectation of meeting all federal and state requirements in order to ensure the MCE's enrollees have access to all services covered under the contract in a timely and culturally competent manner, which take into account any necessary accommodations. The details of some of the key network adequacy and availability of services standards can be found in Appendix G: Provider Network Requirements, Appendix H: MCO Access Standards and Appendix I: DBM Access Standards. MCEs submit reports regarding their members geographic access and the availability of services, allowing MLTC staff to monitor compliance with these contractual requirements for their provider network.

All MCEs annually submit to MLTC a network development plan for review. Within this plan the MCEs must demonstrate their capability of developing and maintaining a provider network which meets all contract requirements. This document is an assurance of the adequacy and sufficiency of the MCE's provider network [42 CFR § 438.206], and ensures that the provision of core benefits and services will occur [42 CFR § 438.207(b) and 42 CFR § 438.207(c)]. The network development plan includes network building activities which occurred in the time since the previous plan submission, along with any applicable future plans the MCEs intend to carry out in order to address any network deficiencies identified, including remediation plans.

### Clinical Practice Guidelines

Development and dissemination of clinical practice guidelines by the MCEs as detailed below ensures the promotion of evidence-based care and that MCE's decisions and member education are consistent with up-to-date standards, requirements for evidence-based practices, and community practice standards in the state.

MLTC does not require the MCEs to adopt specific clinical practice guidelines, but they must be developed by the MCEs in accordance with 42 CFR 438.236(b) and ensure that they:
- o are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- o consider the needs of the MCE's members, including children with serious emotional disorders and adults with serious and persistent mental illness;
- o are adopted in consultation with participating health care professionals;
- o comply with state and federal requirements;
- o are approved in advance by the MCEs Clinical Advisory Committee and MLTC;
- o are reviewed and updated a minimum of annually, as appropriate;
- o are disseminated by the MCEs to all affected providers and, upon request, to enrollees and potential enrollees;
- o are posted to the MCE's website; and
- o provide a basis for consistent decisions for UM, member education, service coverage, and any other areas to which the guidelines apply.

The MCOs must coordinate the development of clinical practice guidelines with other MLTC MCOs to avoid providers receiving conflicting guidelines from different MCOs. The MCEs must monitor the

application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCE's QAPI Committee. Using information acquired through its QM and UM activities, the MCEs must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and utilization review activities.

The clinical practice guidelines utilized by the MCEs contracted in 2023 can be found at the following web locations:

Heathy Blue: https://provider.healthybluene.com/nebraska-provider/resources/manuals-and-guides
Nebraska Total Care: https://www.nebraskatotalcare.com/providers/quality-improvement/practice-guidelines.html
United Healthcare Community Plan: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/multi/clinical-guidelines/Clinical-Practice-Guidelines-UHCCP-Multi-States.pdf
Managed Care of North America: http://docs.mcna.net/misc/cpg-ne

## Intermediate Sanctions

Problems in the quality of care that Medicaid members receive are addressed by intermediate sanctions, as specified in 42 CFR 438 Subpart I. According to CFR 438.700, each state that contracts with an MCE must establish intermediate sanctions that may be imposed if the MCE is found to have not met the contract requirements.

MLTC may impose the following intermediate sanctions at its sole discretion:
- civil monetary penalties as specified in Section IV.V Contract Non-Compliance of the Heritage Health contract;
- appointment of temporary management;
- granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;
- suspension of all new enrollments into the MCE, including auto-assignments, as of the effective date of the sanction;
- suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and
- any other remedy, right, or sanction allowed under the contract or applicable law.

MLTC may install temporary management if it finds that there is continued egregious behavior by the MCE, including, but not limited to, behavior that is described in 42 CFR 438.706, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act. In this circumstance, MLTC must also notify members of the MCE of their right to select another MCE and allow them to do so. MLTC may not delay imposition of temporary management to provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

Since 2020, MLTC has not applied intermediate sanctions to any contracted MCE.

# 4. External Quality Review Arrangements

DHHS has contracted with HSAG as an EQRO to conduct EQR of the contracted MCEs under the Heritage Health Program. HSAG is a national health care assessment organization that is licensed to conduct HEDIS compliance audits by the NCQA, and is accredited by URAC, amongst others. Nationally, HSAG evaluates MCOs, PAHPs, prepaid inpatient health plans (PIHPs), and primary care case management (PCCM) programs as required by the code of federal regulations 42 CFR Part 438, Subpart E, and aggregates information on the timeliness, access, and quality of healthcare services furnished to Medicaid enrollees. For the Heritage Health program, HSAG completes all required EQR activities as described in 42 CFR 438.358(b)(1)(i) through (iii). MLTC does not utilize the non-duplication option.

DHHS contracts with HSAG to complete the following activities:

- Conduct an annual external quality review of the MCEs which utilizes information from mandatory activities per 42 CFR 438.358(b) and produce all required reports
- Perform validation of PIPs to comply with requirements per 42 CFR 438 330(b)(1)
- Provide validation of MCEs performance measures required by DHHS per 42 CFR 438.330(b)(2)
- Perform a review, conducted within the previous 3 year period, to determine the MCEs compliance with the standards in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330.
- Perform validation of MCEs network adequacy to comply with 42 CFR 438.68
- Provide technical assistance to the MCEs:
  - To assist in them in conducting activities related to the mandatory and additional activities that provide information for the EQR
  - In the development and execution of PIPs
- Provide reports in writing to DHHS regarding any problems with the administration of the MCEs contracts, to include proposed corrective action plans for any problems directly related to contract compliance.

MLTC engaged Myers and Stauffer to evaluate encounter data, by assessing the completeness and accuracy of supplemental claims data submitted by all contracted MCEs and used for rate setting for the Heritage Health program.

# 5. Updating the Quality Strategy

## Review and Evaluation

MLTC's Quality Strategy will be reviewed and updated as needed, but no less than once every three years as required by managed care regulations at 42 CFR 438.340(c) and 457.1240(e), or when significant programmatic changes occur. MLTC defines a significant change as the addition of new populations into the Heritage Health program or when a new or different approach is implemented to improve the quality of care.

HSAG has reviewed MLTC's 2020 Quality Strategy and provided the following recommendations, many of which have been taken into consideration during the drafting process of this Quality Strategy:

- Continue to encourage and support each MCE to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and state obligations.
- Continue to support, guide, and work collaboratively with each MCE as they become compliant with requirements. MLTC staff should continue routine operational calls and/or meetings, be available and responsive to MCE's routine and spontaneous communications, and have continual contact and meetings, as needed, to address questions.
- Establish a workgroup to address common improvement opportunities surrounding the EQR-related activities or areas of non-compliance.
- Throughout the annual EQR-related activities, continue striving to improve member experience of care, provider experience, the health of populations, and reduce the per-capita cost of health care services. Additionally, the MCEs and MLTC should continue to meet and discuss difficult-to-place patients, high-cost claimants, and medically/behaviorally complex patients, along with any projects and population-based initiatives.
- Collaborate with HSAG to require each MCE to complete any identified CAPs during the compliance monitoring review.
- Continue to address opportunities for improvement and implement any recommendations, which will facilitate the MCE's improvement in areas of quality, timeliness, and access to care for Nebraska Medicaid members. MLTC should continue the monthly operational meetings with the MCEs as a means to discuss performance as it relates to quality, access, and timeliness of care.
- Continue to effectively manage the oversight and work collaboratively with each MCE to ensure program operations, quality and compliance measures, and reporting are meeting contractual and performance standards.
- Continue to monitor and assess the MCEs performance, along with routinely adjusting performance measures and other EQR-related goals. Additionally, MLTC should encourage and strive for a positive trend in performance for each MCE.
- Consider revising the Quality Strategy to reflect MLTC's goals and objectives. For each objective, MLTC should outline a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the Quality Strategy.

- Collaborate with the MCEs and discuss quality initiatives, best practices, and common barriers to improvement on measures.
- Continue to strive to improve member health outcomes by encouraging MCEs to meet and exceed Quality Strategy goals and holding MCEs accountable for performance.
- Encourage the MCEs to implement interventions targeting performance measures that did not meet the national Medicaid benchmarks.

MLTC engages with all contracted MCEs to support their quality initiatives and help align these interventions with those described in this Quality Strategy. MLTC staff provide continuous quality oversight and contract management of the MCEs by participating in regularly scheduled meetings to discuss topics such as barriers to quality improvement, population-based initiatives, and also meetings to consult on difficult-to-place patients, high-cost claimants, and medically/behaviorally complex patients. MLTC performs in depth compliance oversight to assure that contractual standards for their programs are maintained in the delivery of services to Nebraska's Medicaid managed care enrollees.

MLTC's goals and objectives for improving the quality of the Heritage Health Program have not changed significantly over time, but within this updated Quality Strategy these goals are now tied to a system by which the success of focused interventions can be measured. With this improved structure, moving forward MLTC will perform effectiveness evaluations in order to continually improve our Quality Strategy and update when evaluations point us toward an approach that may be more impactful on quality improvement. MLTC will annually review all quality metrics defined in Appendix A: MCE Performance Measures in order to assess progress towards performance targets.

## Public Comment and Publication

When review of the Quality Strategy indicates that updates are needed due to what the MLTC defines as a significant change the MLTC publishes the draft Quality Strategy on the public notice website at http://dhhs.ne.gov/Pages/Medicaid-Public-Notices.aspx for public feedback. It is also presented to the MCAC for stakeholder input.

In Nebraska there are four federally recognized Tribes, and Medicaid enrollees who are also members of these Tribes are enrolled in the Heritage Health Program. MLTC meets on a quarterly basis with representatives of the Omaha, Ponca, Santee Sioux and Winnebago Tribes, as well as with the CMS Native American contact and the MCO's tribal liaisons. These meetings are held to discuss relevant Medicaid/CHIP matters that impact the Tribes and to invite discussion and comments for consideration. Details for these meetings can be located on the MLTC website at https://dhhs.ne.gov/Pages/Tribal-Relations.aspx. Tribal notice of updates to the Quality Strategy is given in compliance with state tribal consultation policy.

The MLTC collects all stakeholder feedback for review in order to determine if further updates to the Quality Strategy is necessary prior to submission to CMS for comment and feedback. Final versions of MLTC's Quality Strategy are published on the MLTC public website: https://dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx

# Appendix A: MCE Performance Measures

| Aim | Goal | Objective | Quality Measure | Statewide Performance Baseline | Statewide Performance Target for Objective |
|---|---|---|---|---|---|
| Improve the Member Experience of Care | Expand access to high-quality services to meet the needs of diverse clients | Ensure timely access to primary and specialty care | EQRO NAV evaluation | N/A | N/A |
| | | | CAHPS Survey – Getting Care Quickly Aggregated Question Response | 71.96% | 75% |
| | | | CAHPS Survey - Getting Needed Care Aggregated Question Response | 79.17% | 82% |
| | Improve coordination of care | Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management | Follow-Up After Emergency Department Visit for Mental Illness (FUM)<br>• 30 Day Follow-Up<br>• 7 Day Follow-Up | • 30 Day Follow-Up: 60.30%<br>• 7 Day Follow-Up: 39.35% | • 30 Day Follow-Up: 64%<br>• 7 Day Follow-Up: 44% |
| | | | Follow-Up After Emergency Department Visit for Substance Use (FUA)<br>• 30 Day Follow-Up<br>• 7 Day Follow-Up | • 30 Day Follow-Up: 43.47%<br>• 7 Day Follow-Up: 28.41% | • 30 Day Follow-Up: 46%<br>• 7 Day Follow-Up: 30% |
| | | | Ambulatory Care: Emergency Department (ED) Visits (AMB) * Per 12,000 beneficiary months, per HEDIS, to include all age groups. | 591.37 | 585 |
| | Increase member satisfaction | Engage and partner with enrollees to improve enrollee experience and outcomes and increase public awareness about services | CAHPS Survey – Health Plan Customer Service Aggregated Question Response * Per 12,000 beneficiary months, per HEDIS, to include all age groups. | 87.67% | 90% |
| | | | CAHPS Survey - Rating of all Health Care Question Response | 67.92% | 71% |
| Improve the Provider Experience of Care | Timely decision making | Ensure timely payment for claims | Claims Processing Timeliness QPP: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim. | 98.42% | 99% |

| Aim | Goal | Objective | Quality Measure | Statewide Performance Baseline | Statewide Performance Target for Objective |
|---|---|---|---|---|---|
| Improve the Provider Experience of Care (continued) | Timely decision making (continued) | Resolve appeals in a timely manner | Appeal Resolution Timeliness QPP: MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal. | 99.94% | Remain above 99% |
| | Increase provider satisfaction | Streamline provider credentialling by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialling verification subcontractor | Provider Survey | Survey questions in development for 2024 | In development |
| | Build transparent and trusting stakeholder relationships | Conduct regular "listening sessions" where relevant division leadership meet with provider and community constituents at least quarterly to solicit their ideas, suggestions, and feedback for incorporation into policies and program improvements when/where possible. | Provider Survey | Survey questions in development for 2024 | In development |
| Improve the Health of Populations | Promote wellness and prevention | Improve screening rates for cancers | Breast Cancer Screening (BCS) | 56.46% | 59% |
| | | | Colorectal Cancer Screening (COL) | 38.76% | 42% |
| | | | Cervical Cancer Screening (CCS) | 55.88% | 58% |
| | | Promote oral health | Oral Evaluation, Dental Services (OEV-CH) | 45.87% | 50% |
| | | | Topical Fluoride for Children (TFL-CH) | 22.33% | 25% |
| | | | Sealant Receipt on Permanent First Molars (SFM-CH) | 59.66% | 62% |
| | | | Periodontal Evaluation in Adults with Periodontitis (PEV-A) | 40.70% | 42% |

| Aim | Goal | Objective | Quality Measure | Statewide Performance Baseline | Statewide Performance Target for Objective |
|---|---|---|---|---|---|
| Improve the Health of Populations (continued) | Promote wellness and prevention (continued) | Ensure access to care during pregnancy, childbirth and postpartum | Prenatal and Postpartum Care: Postpartum (PPC) | 72.75% | 75% |
| | | | Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)<br>• Most/moderately effective 3 days<br>• Most/moderately effective 90 days<br>• LARC 3 days<br>• LARC 90 days | • Most/moderately effective 3 days: 1.80%<br>• Most/moderately effective 90 days: 41.63%<br>• LARC 3 days: 0.83%<br>• LARC 90 days: 20.75% | • Most/moderately effective 3 days: 3%<br>• Most/moderately effective 90 days: 44%<br>• LARC 3 days: 2%<br>• LARC 90 days: 23% |
| | | | Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)<br>• Most/moderately effective 3 days<br>• Most/moderately effective 90 days<br>• LARC 3 days<br>• LARC 90 days | • Most/moderately effective 3 days: 8.88%<br>• Most/moderately effective 90 days: 38.69%<br>• LARC 3 days: 0.89%<br>• LARC 90 days: 14.02% | • Most/moderately effective 3 days: 10%<br>• Most/moderately effective 90 days: 41%<br>• LARC 3 days: 2%<br>• LARC 90 days: 16% |
| | | Promote healthy development and wellness in children and adolescents | Well-Child Visits in the First 30 Months of Life (W30) | 65.33% | 69% |
| | | | Child and Adolescent Well-Care Visits (WCV) | 46.84% | 50% |
| | | | Lead Screening in Children (LSC) | 70.27% | 73% |
| | | Improve immunization rates | Immunizations for Adolescents (IMA) Combo 2 | 31.86% | 35% |
| | | | Childhood Immunization Status (CIS) Combo 10 | 46.03% | 50% |
| | | Ensure appropriate use of prescription drugs | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) | 64.94% | 67% |
| | | | Asthma Medication Ratio (AMR) | 69.34% | 72% |
| | Improve Chronic disease management and control | Improve hypertension, diabetes, and cardiovascular disease management and control | Controlling High Blood Pressure (CBP-AD) | 71.97% | 75% |
| | | | Diabetes Short-Term Complications Admission Rate (PQI01) *per 100,000 beneficiary months | 14.23 | 14 |

| Aim | Goal | Objective | Quality Measure | Statewide Performance Baseline | Statewide Performance Target for Objective |
|---|---|---|---|---|---|
| Improve the Health of Populations (continued) | Improve Chronic disease management and control (continued) | Improve access to mental health and substance use disorder care | 1115 SUD Metric #11 – Withdrawal Management | 1.02% | 3% |
| | | | 1115 SUD Metric # 12 – Medication Assisted Treatment | 6.34% | 8% |
| | | | Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)<br>• Initiation Phase<br>• Continuation and Maintenance Phase | • Initiation Phase: 45.61%<br>• Continuation and Maintenance Phase: 54.10% | • Initiation Phase: 48%<br>• Continuation and Maintenance Phase: 57% |
| | | | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)<br>• BloodGlucose<br>• Cholesterol<br>• BloodGlucoseCholesterol | • BloodGlucose: 50.94%<br>• Cholesterol: 31.42%<br>• BloodGlucoseCholesterol: 29.16% | • BloodGlucose: 54%<br>• Cholesterol: 35%<br>• BloodGlucoseCholesterol: 32% |
| | | | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) | 58.75% | 60% |
| Reduce the Per Capita Cost of Healthcare | Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions | Reduce the number of emergency department visits for substance use disorders. | 1115 SUD Metric #23 - Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries | 3.48 | 3 |
| | | Increase the percentage of adults who initiate and continue treatment after a diagnosis of alcohol or other drug abuse/dependence. | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)<br>• Initiation of SUD Treatment<br>• Engagement of SUD Treatment | • Initiation of SUD Treatment: 37.63%<br>• Engagement of SUD Treatment: 11.43% | • Initiation of SUD Treatment: 40%<br>• Engagement of SUD Treatment: 14% |
| | | Improve maternal health and reduce the pre-term birth rate in Medicaid beneficiaries. | Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC) | 74.33% | 78% |

# Appendix B: MCO PIP Aims and Interventions

| 01/01/18-12/31/20 | Facilitate and improve the standard of care practice in the use of 17-hydroxyprogesterone in continuously enrolled pregnant women with previous preterm births. | **Member interventions**<br>• Increase knowledge and education on Medicaid eligibility/wait time for new members.<br>• Increase knowledge and education to pregnant members on importance of attending all prenatal visits.<br>• Increase knowledge and education to pregnant members on 17P<br>• Collaborate with other MCOs and Public Health to develop and disseminate educational materials on 17P and/or preterm labor prevention.<br>• Refer all high-risk pregnancies to case management.<br>• Increase knowledge and education to pregnant members on local resources to address Social Determinates of Health (SDOH).<br>• Monitor and increase member attendance for prenatal visits<br>• Conduct analysis of member data to assess risk for prematurity and utilize results to inform member outreach.<br><br>**Provider interventions**<br>• Increase knowledge and education to providers on the Obstetric Need Assessment Form.<br>• Increase knowledge and education to providers on Medicaid eligibility and wait time for new members.<br>• Increase knowledge and education to providers on 17P, to include standard of care guidelines, prior auth and billing processes, and resources available to providers through the drug manufacturer.<br>• Increase knowledge and education to providers on Care and Case Management programs offered by the MCOs.<br>• Assess attendance at prenatal visits: Provider related<br>• Monitor members utilizing 17P to assess for increase in usage. |
|---|---|---|

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|---|---|---|
| | | • Conduct analysis of providers prescribing 17P to identify gaps in care and barriers to the use of 17P.<br>• Conduct analysis of member data to assess risk for prematurity and utilize results to inform provider outreach. |
| 01/01/18-12/31/20 | Improve Tdap immunization rates among pregnant women in Nebraska. | Member Interventions<br>• Increase knowledge and education to members regarding Tdap immunization during pregnancy.<br>• Increase utilization of Tdap immunization among qualified pregnant members.<br>• Case Management Assessment documentation is completed on all high-risk pregnancies.<br>• Collaborate with other MCOs and Public Health to develop and disseminate educational materials on Tdap immunizations for pregnant members.<br><br>Provider Interventions<br>• Increase knowledge and education to providers on Tdap immunization during pregnancy.<br>• Conduct analysis of data to identify and stratify gap report of providers related to Tdap immunizations for pregnant members. |
| 01/01/18-12/31/20 | Improve follow up rates for members diagnosed with a mental health and/or substance use disorder upon discharge from the emergency department. | Member Interventions<br>• Improve outreach to members discharged from the Emergency Department with a primary diagnosis of a mental health and/or substance use disorder.<br>• Encourage involvement in care management for members discharged from the Emergency Department with a primary diagnosis of a mental health and/or substance use disorder.<br>• Assess member access to discharge instructions for post Emergency Department care for members discharged from the Emergency Department with a primary diagnosis of a mental health and/or substance use disorder.<br>• Increase member knowledge and education related to community resources to address primary mental health and substance use diagnosis as well as other Social Determinates of Health (SDOH) needs. |

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| | | • Increase member knowledge and education related to prescribed medications and aid to address barriers and gaps related to obtaining and taking said medications as prescribed.<br><br>Provider interventions<br>• Collaborate with local hospitals to identify members recently discharged from the Emergency Department with a primary diagnosis of a mental health and/or substance use disorder.<br>• Coordinate with local behavioral health providers to assess barriers to follow up care and verify member attendance and ongoing medication management.<br>• Increase providers knowledge and education to regarding available services offered by the Managed Care Organizations.<br>• Increase Emergency Department and ambulatory providers knowledge and understanding regarding mental health and substance use disorder, related HEDIS Measures, and available tools and resources.<br>• Increase knowledge, education and engagement of in-network PCPs and telehealth network providers to address gaps in care. |
| 4/2/20-12/31/21 | Implement interventions, targeted at providers and members to increase the SSD HEDIS® rate. | Member interventions<br>• Assess for barriers to the integration of physical and mental healthcare and develop interventions to ameliorate identified barriers.<br>• Increase member knowledge and education on standards of care, side effects and co-occurring morbidities related to the use of antipsychotics.<br>• Increase member involvement with care management programs offered by the Managed Care Organizations.<br><br>Provider interventions<br>• Increase provider knowledge and education on HEDIS behavioral health quality metrics.<br>• Increase provider knowledge, education, and utilization of integrated care best practices between primary care and mental health providers. |

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|---|---|---|
| | | • Conduct analysis to identify gaps in care and barriers to meeting HEDIS behavioral health measures and coordinate with providers to address the identified gaps and issues. |
| 1/1/2021-current | Implement interventions for members ages 18-64 with acute inpatient and observation stays to decrease unplanned readmissions. | Member Intervention<br>• Increase member knowledge and education related to compliance with treatment recommendations.<br>• Increase member knowledge and education on the benefits of care management programs offered by the Managed Care Organizations to increase utilization.<br>• Ensure coordination between utilization management and case management to increase outreach and engagement in case management for high-risk members.<br>• Increase member knowledge and education related to community resources to address medical, mental health, substance use diagnosis as well as other Social Determinates of Health (SDOH) needs.<br>• Increase member knowledge and education on alternatives options to address access to care issues.<br><br>Provider Intervention<br>• Increase knowledge, education and engagement of in-network PCPs and telehealth network providers to address gaps in care. |
| 1/1/2023 – current | Improve member experience with health plan member services | Interventions:<br>• Conduct quarterly reviews of member call survey results to identify opportunities for staff coaching<br>• Provide coaching to staff for calls receiving a low survey score<br>• Follow up with members to assure information discussed during Member Services call has been received |

| 1/1/2023 – current | Improve member satisfaction with their access to care | Interventions:<br>• Increase the amount of provider ethnicity information by 1% by the end of this project to increase access to care by creating a tool that can be used by parent/guardian to choose the right urgent care provider or specialist for their child base off of their ethnicity preference.<br>• Expand obstetrics and pediatric provider network to increase access to care in geographic areas with low access to these specialties.<br>• Develop web based search platform to assist members in finding resources to reduce SDOH barriers to care<br>• Perform health risk screening with new members and annually for existing members in order to identify SDOH barriers to care |
|---|---|---|
| 1/1/2023 – current | Increase notification of pregnancy rate | Provider Intervention:<br>• Provider education on the importance of completing a notice of pregnancy<br>• Provider incentive for the completion of notice of pregnancy<br><br>Member Intervention<br>• Member education on the importance of notifying their health plan of their pregnancy<br>• Member incentive for notifying their health plan of their pregnancy<br>• Enhanced member communication on reward programs available for pregnant members |

## Appendix C: DBM PIP Aims and Interventions

| 01/01/18-12/31/20 | Implement interventions, targeted at providers and members to increase the rate of preventative dental visits. | Member interventions<br>• Increase member knowledge and education regarding the importance of regular preventative dental visits across the lifespan.<br><br>Provider interventions<br>• Increase the preventative usage of fluoride among providers.<br>• Increase medical provider knowledge and education regarding the importance of preventative dental visits and increase collaboration among medical and dental providers. |
|---|---|---|
| 01/01/18-12/31/20 | Implement interventions, targeted at providers and members to increase the rate of annual dental visits. | Member interventions<br>• Increase member knowledge and education regarding the importance of annual dental visits across the lifespan.<br><br>Provider interventions<br>• Increase the preventative usage of fluoride among providers.<br>• Increase medical provider knowledge and education regarding the importance of annual dental visits and increase collaboration among medical and dental providers. |
| 01/01/21-current | First dental visit by age 1 | Member intervention<br>• Increase knowledge and education on the importance of oral exam for infants at or near the first birthday.<br><br>Provider intervention<br>• Increase knowledge and education regarding providers performance related to this metric. |

| 1/1/2023-current | Increasing the Percentage of Providers Receiving Cultural Competency Training | Interventions: <ul><li>Incorporate cultural competency training into Provider Relations site visits</li><li>Add cultural competency training to online provider portal</li><li>Conduct monthly targeted provider calls to those who have not completed cultural competency training to make them aware of training opportunities</li></ul> |
| --- | --- | --- |

# Appendix D: Neb. Rev. Stat. §68-995

68-995 Contracts and agreements; department; duties.

All contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for health services entered into by the department and existing on or after August 11, 2020, shall:

(1) Provide a definition and cap on administrative spending such that (a) administrative expenditures do not include profit greater than the contracted amount, (b) any administrative spending is necessary to improve the health status of the population to be served, and (c) administrative expenditures do not include contractor incentives. Administrative spending shall not under any circumstances exceed twelve percent. Such spending shall be tracked by the contractor and reported quarterly to the department and electronically to the Clerk of the Legislature;

(2) Provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that profit shall not exceed a percentage specified by the department but not more than three percent per year as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidiary companies and risk-bearing partners, under the contract;

(3) Provide for return of (a) any remittance if the contractor does not meet the minimum medical loss ratio, (b) any unearned incentive funds, and (c) any other funds in excess of the contractor limitations identified in state or federal statute or contract to the State Treasurer for credit to the Medicaid Managed Care Excess Profit Fund;

(4) Provide for a minimum medical loss ratio of eighty-five percent of the aggregate of all income and revenue earned by the contractor and related parties under the contract;

(5) Provide that contractor incentives, in addition to potential profit, be up to two percent of the aggregate of all income and revenue earned by the contractor and related parties under the contract; and

(6) Be reviewed and awarded competitively and in full compliance with the procurement requirements of the State of Nebraska.

Source: Laws 2012, LB1158, § 2.; Laws 2016, LB1011, § 1; R.S. 1943, (2018), § 71-831; Laws 2020, LB 1158, § 2

## Appendix E: Heritage Health MCO 2023 Quality Performance Program Measures

| Base Performance Requirement | 40% Payment Threshold | Full Payment Threshold | % of Payment Pool |
|---|---|---|---|
| **Claims Processing Timeliness - 15 Days:** Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim. | N/A | 95% within 10 business days | 5% |
| **Encounter Acceptance Rate:** Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications. | N/A | 98% | 10% |
| **Appeal Resolution Timeliness:** MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal. | N/A | 95% within 20 days | 5% |
| **Breast Cancer Screening (BCS-AD):** Percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer. | 53.96% | 56.52% | 5% |
| **Prenatal and Postpartum Care: Postpartum Care (PPC-AD):** Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. | 74.94% | 77.37% | 7.5% |
| **Controlling High Blood Pressure (CBP-AD):** Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year. | 59.85% | 63.5% | 5% |

| | | | |
|---|---|---|---|
| **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD):** Percentage of beneficiaries age 18 and older (Combining age groups 18-64 and 65+) with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:<br>• **Initiation of AOD Treatment**. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis<br>• **Engagement of AOD Treatment**. Percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit | Total AOD abuse of dependence Initiation 41.68%<br><br>Total AOD abuse of dependence Engagement 11.22% | Total AOD abuse of dependence Initiation 43.74%<br><br>Total AOD abuse of dependence Engagement 14.08% | 7.5%<br><br><br><br><br>7.5% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH):** Percentage of adolescents ages 12 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year:<br>• Body mass index (BMI) percentile documentation<br>• Counseling for nutrition<br>• Counseling for physical activity | BMI 70.63%<br><br>Counseling for Nutrition 63.36%<br><br>Counseling for Physical Activity 63.33% | BMI 73.57%<br><br>Counseling for Nutrition 69.8%<br><br>Counseling for Physical Activity 70.06% | 5%<br><br>5%<br><br><br>5% |
| **Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH):** Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP. | 82.73% | 85.4% | 7.5% |
| **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH):** Percentage of adolescents ages 12 to 17 who had two or more antipsychotic prescriptions and had metabolic testing:<br>• Percentage of adolescents on antipsychotics who received blood glucose and cholesterol testing | Blood Glucose and Cholesterol Testing: 33.33% | Blood Glucose and Cholesterol Testing: 36.86% | 7.5% |

| | | | |
|---|---|---|---|
| **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH):** Percentage of adolescents ages 12 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. | 63.76% | 67.71% | 7.5% |
| **Immunizations for Adolescents (IMA) Combo 2** | 31.87% | 35.04% | 7.5% |
| **Childhood Immunization Status (CIS) Combo 10** | 49.76% | 55.18% | 2.5% |
| **Plan All-Cause Readmissions (PCR-AD):** For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:<br>• Count of Index Hospital Stays (IHS)<br>• Count of Observed 30-Day Readmissions<br>• Count of Expected 30-Day Readmissions | Monitoring Metric Only | Monitoring Metric Only | NA |
| **Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD):** Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:<br>• A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)<br>• Four separate rates representing the following types of FDA-approved drug products:<br>   ○ Buprenorphine (Rate 2)<br>   ○ Oral naltrexone (Rate 3)<br>   ○ Long-acting, injectable naltrexone (Rate 4)<br>   ○ Methadone (Rate 5) | Monitoring Metric Only | Monitoring Metric Only | NA |

## Appendix F: DBM 2023 Quality Performance Program Measures

| Base Performance Requirement | Payment Threshold | % of Payment Pool |
|---|---|---|
| **Claims Processing Timeliness - 15 Days**: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the MCO receives the claim. | ≥ 95% within 15 days | 5% |
| **Reporting timeliness:** Contractually required report submissions and resubmittals, when requested by MLTC, must be submitted on or before the applicable deadline | 95% submitted on or before due date | 5% |
| **Report Accuracy:** Reports submitted must be accepted by MLTC pursuant to MLTC specifications. | 90% accepted by MLTC | 5% |
| **Encounter Acceptance Rate:** 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications. | ≥ 98% | 15% |
| **Appeal Resolution Timeliness:** The DBM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within twenty (20) calendar days from the day the DBM receives the appeal. | ≥ 95% within 20 days | 10% |
| **Topical Fluoride for Children at Elevated Caries Risk (Dental or Oral Health) (TFL-CH-A):** Percentage of children aged 1-21, who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications as a dental OR oral health services within the reporting year. | 30% | 15% |

# Appendix G: Provider Network Requirements

The following describes the provider network requirements all MCEs must follow in order to be in compliance with their contract with DHHS, Section V.I.

## General Provider Network Requirements

- The network must be supported by written contracts between the MCO and its providers. Providers must first be enrolled with Nebraska Medicaid.
- The MCO must ensure that network providers offer hours of operation that are no shorter in duration than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.
- There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.
- The MCO must have available non-emergent after-hours physician or primary care services within its network.
- Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in Appendix H – MCO Access Standards and Appendix I DBM Access Standards. The MCO must ensure that providers are available within these requirements.
- The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements.
- The MCO must make a good faith effort to contract with urgent care centers in Nebraska to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.
- In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.
- In all its contracts with health care professionals, the MCO must comply with the requirements specified in 42 CFR §§ 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.
- The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR § 438.206(c)(2).
- The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.

- The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.

## Mainstreaming of Members

- To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same.
- Examples of prohibited practices include, but are not limited to, the following:

  - Denying or not providing a member any covered service or access to an available facility;
  - Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary;
  - Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
  - Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.

- If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.
- If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider to come into compliance within 30 (thirty) calendar days and notify MLTC in writing.  Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.

## Establishing a Network

- The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members.  The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement prior to the Contract Start Date and any time there is a significant change (as defined by the state) in the MCO's operations that impacts services.
- The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, dentists, dental specialists (endodontists, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists), and

pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.

- The MCO must provide an adequate network of PCPs to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are Doctors of Medicine (MDs) or Doctor of Osteopathic Medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

- The MCO must maintain a network of qualified providers that meets appointment availability and geographic access standards defined in Appendix H: MCO Access Standards and Appendix I: DBM Access Standards and all requirements in this section. Appendix J – Nebraska Counties Classified by Urban/Rural/Frontier Status provides a map of Nebraska counties classified by urban, rural, and frontier status, as this classification is referenced in the access standards.

- The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members.

- The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.

- For members who meet Special Health Care Needs (SHCN) criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

- The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions:

  - Co-occurring mental health and substance use disorders;
  - Co-occurring mental health and substance use disorders and developmental disabilities;
  - Serious and persistent mental illness;
  - Severe emotional disturbance among children and adolescents, including coordinated care for children served by DHHS or other state agencies (e.g., Children and Family Services, Probation, Developmental Disabilities, etc.);
  - Sex-offending behaviors;
  - Eating disorders; and
  - Co-occurring Serious Mental Illness and common chronic physical illnesses.

- The MCO must contract with providers who demonstrate a commitment to the behavioral health principles of care defined in the MCO contract, including principles of rehabilitation and recovery from mental illness and substance use disorder; a focus on recovery-oriented, trauma-informed services and trauma-specific treatment (e.g., trauma-focused cognitive behavioral therapy);

consumer and family involvement in program management and oversight; a family-driven and strengths-based approach to working with children and their families; cultural and linguistic competency; and training for staff about these principles.

- If any service or provider type is not available to a member within the mileage radius specified in Appendix H: MCO Access Standards and Appendix I: DBM Access Standards, the MCO must submit to MLTC verification that the covered services are not available within the required distance.
- The MCO is not precluded from making arrangements with a provider outside Nebraska for members to receive a higher level of skill or specialty than the level that is available within Nebraska.

## Adequate Capacity

When establishing and maintaining the network, the MCO must consider:

- Its anticipated Medicaid enrollment;
- The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
- The numbers of network providers who/that are not accepting new Medicaid patients;
- The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities; and
- Members with SHCN, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with developmental disabilities.
- The ability of network providers to communicate with limited English proficient members in their preferred language.
- The availability of triage lines of screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

## Dental Provider Network

- The MCO must include in its Provider Network Development Management Plan, detailed in this section, a plan for establishing Dental Homes for members. The Dental Home plan must, at a minimum, address the following topics:

  o Outreach to potential Dental Home participating providers;
  o Policies and procedures for establishing and monitoring the Dental Home program including, but are not limited to:
    - Covered services in the amount, duration, and scope that the MCO recommends should comprise the Dental Home package. This package of services will be finalized with MLTC input and approval prior to contract start;
    - Referrals to dental specialists when care cannot be provided directly within the Dental Home;

- - Education topics to be addressed in the Dental Home setting; and
  - Guidelines for the management of acute dental trauma.
  - o Strategies for encouraging member participation, with a particular focus on parents or guardians of members six (6) to 35 (thirty-five) months of age.
- Access to Specialty Dental Providers
  - o The MCO must ensure the availability of access to specialty providers. The MCO must ensure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.
  - o The MCO must establish and maintain a provider network of dental specialists adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:
    - The MCO has signed a contract with providers of the specialty types listed below who accept new members and are available at least on a referral basis.
    - The MCO must ensure, at a minimum, the availability of the following providers:
      - Endodontists,
      - Oral Surgeons,
      - Orthodontists,
      - Pedodontists,
      - Periodontists, and
      - Prosthodontists.
    - The MCO must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.
    - In accordance with 42 CFR § 438.208(c)(4) for members determined to need a course of treatment, the MCO must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

## Pharmacy Network

- The MCO must accept into its network any pharmacy or pharmacist participating in the Medicaid program provided the pharmacy or pharmacist is licensed and in good standing with MLTC and accepts the terms and conditions of the contract offered to them by the MCO.
- The MCO or its contracted Pharmacy Benefits Manager (PBM) must obtain an active agreement from a participating pharmacy provider prior to the start of services under this contract for that pharmacist to be considered a network provider, even if that pharmacy has an existing relationship for non-Medicaid services with that MCO or its PBM. The pharmacy provider must agree to the terms of the MCO's PBM contract for the Nebraska Medicaid program.
- The MCO may contract with specialty pharmacies to ensure the adequate availability of specialty drugs. The MCO may limit distribution of specialty drugs to a network of pharmacies that meet reasonable requirements to distribute specialty drugs. The MCO may not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the MCO's contract with its specialty pharmacies.

- The MCO may utilize mail-order pharmacies in its network, but must not require or incentivize members to use a mail-order pharmacy, including through different member copays. Members who opt to use this service must not be charged fees, including postage and handling fees.
- The MCO must not designate preferred pharmacies within its network or offer incentives to members to use a designated pharmacy.

## Non-Emergency Medical Transportation (NEMT)

- The MCO must ensure that any NEMT network providers deliver service that allows members to arrive promptly for appointments, so that there is not an excessive wait for their transportations. The pick-up and wait times should align with the following requirements. (Contract Section V.E.29.i.)

  o The wait time for a pick-up to a scheduled appointment must not exceed sixty (60) minutes prior to the scheduled appointment time.
  o The member must not wait more than thirty (30) minutes from drop-off time to their scheduled appointment time.
  o The wait time for a scheduled return trip, after an appointment, must not exceed sixty (60) minutes.
  o Member's may be picked up on a "will call" basis, which must also not exceed sixty (60) minutes wait time after the NEMT provider is contacted for the return trip.
  o For multiple passenger trips, which are only allowed for commercial providers when the first member approves multi-loading, members should not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for transport, for an individual client using that mode, from the point of pick-up to the destination.
  o Exceptions to service delivery times specified herein may be made for trips with pick-up or destinations outside of the member's local area or verified scheduled consecutive trips.
  o Exceptions may also be made due to unusual situations such as exceptional distances in rural areas or other situations out of the control of the NEMT provider.
  o During periods of inclement weather conditions, the MCO's broker shall have written procedures in place that at a minimum includes notifying the members of the delay, the alternative schedule, and any alternative pick-up arrangements.
  o The provider must wait 30 minutes following the scheduled pick-up time before departing without the member.

# Appendix H: MCO Access Standards

The following describes the Appointment Availability and Access Standard requirements all MCEs must follow in order to be in compliance with their contract with DHHS, Section V.I.

## Appointment Availability Access Standards

- Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.
- Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.
- Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.
- Family planning services must be available within 7 calendar days.
- Non-urgent, preventive care must be available within 4 weeks.
- PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.
- For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within 1 month of referral or as clinically indicated.
- Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.
- Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

## Geographic Access Standards

- The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties.
- The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members.
- The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs. In urban counties, a network retail pharmacy must be available within 5 miles of 90% of members' personal residences. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.
- The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.
- The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient

assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

- The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the state on the basis of community standards.
- The MCO must contract with a sufficient number of general optometrists to ensure that transport time will be the usual and customary, not to exceed thirty (30) minutes in urban areas, sixty (60) minutes in rural areas, and ninety (90) minutes in frontier areas.
- The MCO must contract with a sufficient number of ophthalmologists to ensure that transport time will be the usual and customary, not to exceed thirty minutes in urban areas, and 90 minutes in rural/frontier areas.

# Appendix I: DBM Access Standards

The following describes the Appointment Availability and Access Standard requirements the DBM must follow in order to be in compliance with their contract with DHHS, Section IV.I

## Waiting Times and Timely Access

- The DBM must ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards.
- Formal policies and procedures establishing appointment standards must be submitted for initial review and approval during the readiness review process. Revised versions of these policies and procedures should be submitted to MLTC for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, MLTC staff must be notified in writing 30 calendar days prior to implementation. Methods for educating both the providers and the members about appointment standards must be addressed in these policies and procedures. The DBM must disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBM must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.
- Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by the DBM through other arrangements.
- Routine or preventative dental services within six (6) weeks.
- Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.
- The DBM must establish processes to monitor and reduce the appointment "no-show" rate for primary care dentists. As best practices are identified, MLTC may require implementation by the DBM. This information must be provided to MLTC during the readiness review process.
- The DBM must have written policies and procedures about educating its provider network about appointment time requirements and provide these to MLTC for approval during the readiness review process. The DBM must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards must be included in the Provider Manual. The DBM is encouraged to include the standards in the provider contracts.

## Geographic Access Standards

- The DBM must, at a minimum, contract with two (2) dentists within forty-five (45) miles of the personal residences of members in urban counties; one (1) dentist within sixty (60) miles of the personal residences of members in rural counties; and one (1) dentist within one hundred (100) miles of the personal residences of members in frontier counties.
- The DBM must, at a minimum, contract with following dental specialists:
  - One (1) oral surgeon, One (1) orthodontist, One (1) periodontist and One (1) pedodontist within forty- five (45) miles of the personal residences of members in urban counties.

- One (1) oral surgeon, One (1) orthodontist, One (1) periodontist and One (1) pedodontist within sixty (60) miles of the personal residences of members in rural counties.
- One (1) oral surgeon, One (1) orthodontist, One (1) periodontist and One (1) pedodontist within one- hundred (100) miles of the personal residences of members in frontier counties.

## Appendix J: Nebraska Counties Classified by Urban/Rural/Frontier Status



**County Classification**

- Frontier
- Rural
- Urban
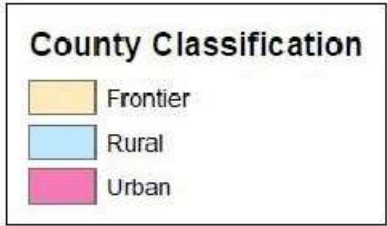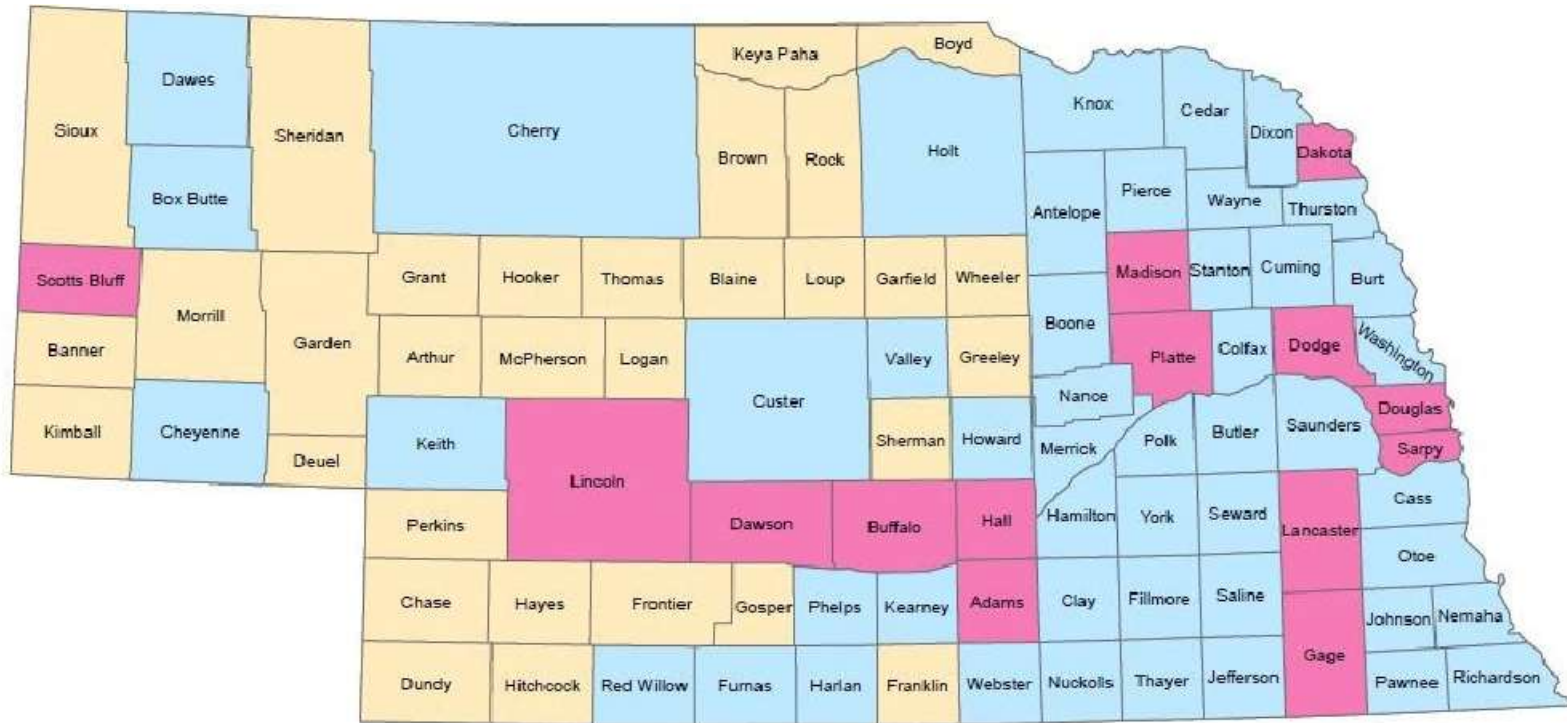
Source: 2010 Census, US Census Bureau

## Appendix K: List of Abbreviations and Acronyms

AABD: Aid to the Aged, Blind, or Disabled

ADD: Attention deficit disorder

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CAP: corrective action plan

CFR: Code of Federal Regulations

CFS: DHHS Division of Children and Family Services

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

CoC: Continuum of Care

DBH: DHHS Division of Behavioral Health

DBM: dental benefits manager

DD: DHHS Division of Developmental Disabilities

DHHS: Nebraska Department of Health and Human Services

DMA: data management and analytics

DO: Doctor of Osteopathic Medicine

DQA: Dental Quality Alliance

ED: Emergency department

EQR: External quality review

EQRO: External quality review organization

FIDE DSNP: Fully integrated dual eligible special needs plan

FFS: Fee-for-service Medicaid delivery system

FWA: Fraud, Waste and Abuse

FQHC: Federally qualified health centers

HCBS: Home and community-based services

HEDIS: Healthcare Effectiveness Data and Information Set

HH: Heritage Health Managed Care Program

HHA: Heritage Health Adult Program

HIS: Health information system

HSAG: Health Services Advisory Group

IMD: Institution for mental disease

LB: Legislative bill

MCAC: Medical Care Advisory Committee

MCE: Managed care entity

MCO: Managed care organization

MD: Doctor of Medicine

MLR: Medical loss ratio

MLTC: DHHS Division of Medicaid and Long-Term Care

MMIS: Medicaid Management Information System

NAC: Nebraska Administrative Code

NCQA: National Committee for Quality Assurance
NE: Nebraska
NEMT: Non-emergency medical transportation
NHC: Nebraska Health Connection
NHAP: Nebraska Homeless Assistance Program
PAHP: Prepaid ambulatory health plan
PCP: Primary care provider
PIHP: Prepaid inpatient health plan
PIP: Performance improvement project
PPACA: Patient Protection and Affordable Care Act
PHE: Public Health Emergency
QAPI: Quality assessment and performance improvement
QM: Quality management
QPP: Quality Performance Program
RFP: Request for proposals
RHC: Rural health center
SHCN: Special health care need
SUD: Substance use disorder
UM: Utilization management
UNMC: University of Nebraska Medical Center
URAC: Utilization Review Accreditation Commission
VBP: Value-based purchasing

# Appendix L: Glossary of Key Terms

**Consumer Assessment of Healthcare Providers and Systems (CAHPS):** An annual nationwide survey that is used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.

**Code of Federal Regulations (CFR):** The official compilation of federal rules and requirements.

**Children's Health Insurance Program (CHIP):** Nebraska's CHIP program is a combination Medicaid CHIP state with a Medicaid CHIP expansion program under Title XXI called "Kid's Connection." Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the federal poverty level.

**Care management:** Comprehensive care coordination and appropriate interventions that reduce health risks and decrease cost of care.

**Case management:** A collaborative process of assessment, planning, facilitation, coordination, and advocacy for options and services that the MCO must conduct to meet an individual's health needs, through communication and provision of available resources to promote quality, cost-effective outcomes.

**Centers for Medicare & Medicaid Services (CMS):** The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

**External quality review organization (EQRO):** Federal law and regulations require States to use an EQRO to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.

**Emergency department (ED):** A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

**Federally qualified health centers (FQHC):** A designation that includes all organizations receiving grants under Section 330 of the Public Health Service Act.

**Fully Integrated Dual Eligible Dual Special Needs Plan (FIDE DSNP):** A health plan which fully integrates care for beneficiaries eligible for Medicare and Medicaid under a single managed care organization.

**Healthcare Effectiveness Data and Information Set (HEDIS):** A set of standard performance measures that give information about the quality of a health plan, e.g. quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare & Medicaid Services (CMS) collects HEDIS data for Medicare and Medicaid plans.

**Health information system (HIS):** A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data that may include digitized audio and video and documents, as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling or facilitating a business process or related transaction.

**Long-term care:** A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

**Long-term services and supports (LTSS)**: Specific Medicaid-covered services including intermediate care facility services for individuals with developmental disabilities, any institutional long-term care or nursing facility services at a custodial level of care, services provided via a Home and Community Based Waiver program, Targeted Case Management, or Medicaid State Plan Personal Assistance Services.

**Managed care organization (MCO):** A private entity that contracts with MLTC to provide benefits and services to Nebraska Medicaid enrollees in exchange for a monthly prepaid capitated amount per member.

**Medical loss ratio (MLR):** The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for members and allowable quality improvement expenses under this contract.

**Medical necessity**: Health care services and supplies that are medically appropriate and:

1. Necessary to meet the basic health needs of the member.
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her physician.
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. No more intensive level of service than can be safely provided.

**National Committee for Quality Assurance (NCQA):** A non-profit organization that accredits and measures the quality of care in Medicare health plans.

**Nebraska Medicaid Program (NE Medicaid or Medicaid):** NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers NE Medicaid is administered by the Division of

Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services (DHHS).

**Primary care provider (PCP):** A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can serve as PCPs are Doctors of Medicine (MDs) or Doctors of Osteopathic Medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

**Performance improvement projects (PIPs):** Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by MLTC and can be of the MCO/PHPs choosing or prescribed by MLTC.

**Performance measures:** A gauge used to assess the performance of a process or function of any organization. These are quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspects of health care services. Performance measures included here may include measures calculated by MLTC (from encounter data or another data source), or measures submitted by the MCO/PHP.

**Quality management:** The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services and maintaining established guidelines and standards reflective of the current state of health knowledge.

**Request for proposal (RFP):** A written solicitation utilized for obtaining competitive offers.

**Rural health centers (RHCs):** An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.