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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2023–2024 External Quality Review Technical Report

for

Heritage Health Program

April 2024

This report was produced for the Division of Medicaid and Long-Term Care by Health Services Advisory Group, Inc.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Background

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (collectively referred to as managed care entities [MCEs] in this report) for administering Medicaid and Children's Health Insurance Program (CHIP) programs, to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

Heritage Health Program

Heritage Health, Nebraska's Medicaid and CHIP managed care program, is administered by MLTC, a division within DHHS. The current MCE contracts are full-risk, capitated managed care contracts. Managed care to administer the Medicaid and CHIP programs in Nebraska was developed to improve the health and wellness of Nebraska's Medicaid and CHIP members by increasing access to comprehensive health care services in a cost-effective manner. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), DHHS contracts with three MCOs to provide physical and behavioral health care, and pharmacy services; and one dental PAHP to provide dental services for Nebraska's Medicaid and CHIP members. Notable features of Nebraska's Medicaid and CHIP programs include the integration of physical and behavioral health care for all 93 counties in the State of Nebraska. During calendar year 2023, DHHS used the exemption option allowed under 42 CFR §438.362 to exempt **United Healthcare Community Plan**'s (**UHCCP**'s) Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) and **Nebraska Total Care**'s (**NTC**'s) Dual Eligible Special Needs Plan (D-SNP) from EQR.

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Feb 5, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 5, 2024.

On April 15, 2022, DHHS issued a request for proposal for the purpose of selecting qualified bidders to provide a full-risk, capitated Medicaid managed care program for physical health, behavioral health, pharmacy, and dental services. In January 2023, DHHS awarded three MCOs a contract that began January 1, 2024, operating through December 31, 2029. DHHS awarded the contract to **UHCCP**, **NTC**, and a new MCO, **Molina Healthcare of Nebraska** (**Molina**). Therefore, starting January 1, 2024, the Heritage Health Program will have three MCOs providing physical health, behavioral health, pharmacy, and dental services.

Table 1-1—Heritage Health MCEs

MCE	Services Provided
Healthy Blue (**HBN**) (contract ended December 31, 2023)	Physical and behavioral health care, and pharmacy services
Molina Healthcare of Nebraska (**Molina**)[1-3] (contract started January 1, 2024)	Physical and behavioral health care, pharmacy services, and dental services
Nebraska Total Care (**NTC**)	Physical and behavioral health care, and pharmacy services (and dental services starting on January 1, 2024)
United Healthcare Community Plan (**UHCCP**)	Physical and behavioral health care, and pharmacy services (and dental services starting on January 1, 2024)
Managed Care of North America, Inc. (**MCNA**) (contract ended December 31, 2023)	Dental services

Scope of External Quality Review

In contract year (CY) 2023–2024, HSAG conducted the mandatory EQR-related activities. The mandatory activities conducted were:

- **Validation of performance improvement projects (PIPs) (Protocol 1).** HSAG validated the ongoing PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner. For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[1-4]

[1-3] **Molina** will not have EQR activity results to report in the CY 2023–2024 annual technical report since its contract with DHHS started on January 1, 2024.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

- **Validation of performance measures—HEDIS methodology (Protocol 2).** As set forth in 42 CFR §438.358, HSAG conducted the validation of performance measures activity in compliance with the CMS protocols released in February 2023.[1-5] Each MCO underwent an NCQA HEDIS Compliance Audit through an NCQA licensed HEDIS auditor to assess its performance on measures selected by DHHS for review. The HEDIS Compliance Audit also determined the extent to which performance measures calculated by the MCOs followed specifications required by NCQA. HSAG obtained each MCO's HEDIS data and final audit report (FAR) produced by the MCO's HEDIS auditor, and evaluated the data and report to ensure that the HEDIS audit activities were conducted as outlined in the NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[1-6]
- **Validation of performance measures—Dental PAHP (Protocol 2).** As set forth in 42 CFR §438.358, HSAG conducted the validation of performance measures activity in compliance with the CMS protocols released in February 2023.[1-7] HSAG validated the performance of Nebraska's dental benefits manager (DBM), **MCNA**, on performance measures selected by DHHS for review. The validation assessed the accuracy of performance measures reported by **MCNA** and determined the extent to which performance measures calculated by the DBM followed specifications required by DHHS.
- **Assessment of compliance with Medicaid and CHIP managed care regulations (compliance with regulations) (Protocol 3).** As set forth in 42 CFR §438.358, HSAG conducted the compliance with regulations activity in compliance with the CMS protocols released in February 2023.[1-8] Assessment of compliance with regulations was designed to determine the MCEs' compliance with their contracts with DHHS and with State and federal managed care regulations.
- **Validation of network adequacy (Protocol 4).[1-9]** HSAG conducted an evaluation of the MCEs' compliance with Heritage Health contract standards for geographic access to care. HSAG conducted a network capacity analysis, comparing the number of providers in each MCE-contracted provider network to the number of members enrolled with the MCE. In addition, the geographic distribution of the MCEs' contracted providers was evaluated relative to their member populations by calculating the percentage of members with the access to network providers required by the contractual geographic access standards.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

[1-6] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

[1-8] Ibid.

[1-9] This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

Reader's Guide

Report Purpose and Overview

To comply with federal health care regulations at 42 CFR Part 438, DHHS contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that HSAG conducted with the Heritage Health MCEs[1-10] throughout CY 2023–2024. This technical report is intended to help the Nebraska Heritage Health Program to:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance health care delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCEs that it contracts with for services.
- Help the MCEs improve their performance with respect to the quality, timeliness, and accessibility of care.

How This Report Is Organized

Section 1—Executive Summary includes a brief introduction to the Medicaid and CHIP managed care regulations and the authority under which this report must be produced. It also describes Nebraska's Medicaid and CHIP managed care program as well as the scope of the EQR-related activities conducted during CY 2023–2024.

The Executive Summary also includes the Reader's Guide. The Reader's Guide provides the purpose and overview of this EQR annual technical report; an overview of the scope of each EQR activity performed; This section also provides a brief overview of how this report is organized and the definitions for "quality," "timeliness," and "access" used by CMS, NCQA, and HSAG to create this report.

Section 2—Comparative Statewide Results provides statewide comparative results organized by EQR activity, and statewide trends and commonalities used to assess the quality, timeliness, and accessibility of services provided by the MCEs and to derive statewide conclusions and recommendations. This section also includes any conclusions drawn and recommendations identified for statewide performance improvement, as well as an assessment of how DHHS can target goals and objectives of the State's quality strategy to better support the improvement of the quality, timeliness, and accessibility of care provided by the MCEs.

[1-10] **Molina**'s results of all EQR-related activities will be reported in the CY 2024–2025 annual EQR technical report.

Section 3—Methodology contains the following information for each EQR activity (i.e., validation of PIPs, validation of performance measures, assessment of compliance with Medicaid managed care regulations, and network adequacy validation [NAV]):

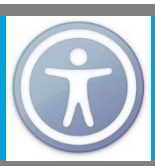
- Objectives
- Technical methods of data collection
- Description of data obtained
- How data were aggregated and analyzed
- How conclusions were drawn
- Information systems (IS) standards review and performance measure results (validation of performance measures only)

This section also describes how HSAG aggregated and analyzed statewide data.

Appendices A–D provide for each MCE an activity-specific presentation of results of the EQR-related activities and an assessment of the quality, timeliness, and accessibility of care and services as applicable to the activities performed and results obtained. These appendices also present activity-specific conclusions and recommendations based on CY 2023–2024 EQR-related activities, as well as follow-up on recommendations made based on the prior year's EQR-related activities. Additionally, a more in-depth explanation of the NCQA IS standards is provided in *Appendix E* of this report.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the Medicaid MCEs in each of the domains of quality, access, and timeliness.

		
Quality	**Access**	**Timeliness**
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[2]	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] Ibid.

[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

2. Statewide Comparative Results

Validation of Performance Improvement Projects

Results

Table 2-1 summarizes the CY 2023–2024 PIP performance for each MCE. Each MCE conducted a PIP focusing on a topic as directed by DHHS. Table 2-1 also presents the validation status.

Table 2-1—Statewide PIP Results for MCEs

MCE	PIP Topic	Clinical or Nonclinical Topic	Overall Validation Status
HBN	*Plan All-Cause Readmissions*	Clinical	*Met*
HBN	*Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)*	Nonclinical	*Partially Met*
NTC	*Plan All-Cause Readmissions*	Clinical	*Met*
NTC	*Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*	Nonclinical	*Met*
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	Clinical	*Met*
UHCCP	*Improving the Member Experience with the Health Plan's Member Services*	Nonclinical	*Met*
MCNA	*First Dental Visit at Age 1*	Clinical	*Met*
MCNA	*Increasing the Percentage of Providers Receiving Cultural Competency Training*	Nonclinical	*Met*

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects

For the MCEs statewide, the following conclusions were identified:

- Three of the four MCEs reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs. **[Quality]**
- The MCEs followed methodologically sound designs for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCEs conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**

For the MCEs statewide, the following opportunities for improvement were identified:

- Two of the four MCEs reported indicator results for the *Plan All-Cause Readmissions* PIP that demonstrated a decline in performance from baseline to Remeasurement 2. **[Quality]**

For the MCEs statewide, the following recommendations were identified:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The MCEs should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were uniformly captured, reported, and presented, HSAG evaluated each MCO's IS capabilities for accurate HEDIS reporting. HSAG reviewed the IS capabilities assessments of the MCOs, which were conducted by licensed organizations (LOs) and included in the FARs. The review specifically focused on those system aspects that could have impacted the reporting of the selected HEDIS Medicaid measures.

When conducting HEDIS Compliance Audits, the terms "information system" and "IS" are used broadly to include the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation includes a review of any manual processes that may have been used for HEDIS reporting as well. The LO determined if the MCOs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

In accordance with NCQA's *HEDIS MY 2022 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that the MCOs' IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. The MCOs may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

The section that follows provides a summary of the MCOs' key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix E* of this report.

Table 2-2—Summary of Compliance With IS Standards

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored. • Contracted vendors are regularly monitored against expected performance standards.	All MCOs were compliant with IS Standard 1.0 for medical services data capture and processing. All MCOs only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCOs continually assess data completeness and take steps to improve performance. • The MCOs effectively monitor the quality and accuracy of electronic submissions. • The MCOs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	All MCOs were compliant with IS Standard 2.0 for enrollment data capture and processing. The MCOs had policies and procedures in place for submitting electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	All MCOs were compliant with IS Standard 3.0 for practitioner data capture and processing. The MCOs appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, the MCOs reviewed all provider data received from delegated entities.
IS 4.0—Medical Record Review (MRR) Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	All MCOs were compliant with IS Standard 4.0 for MRR processes. Data collection tools used by the MCOs were able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for electronic clinical data system (ECDS) reporting met reporting requirements. • NCQA validated data resulting from the Data Aggregator Validation (DAV) program met reporting requirements.	All MCOs were compliant with IS Standard 5.0 for supplemental data capture and processing. The HEDIS repositories contained all data fields required for HEDIS reporting. In addition, the appropriate quality processes for the data sources were reviewed and determined if primary source verification (PSV) was needed on all supplemental data that were in nonstandard form.
IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	All MCOs were compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by the MCOs' staff members. Data were verified for accuracy at each data merge point.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	All MCOs were compliant with IS Standard 7.0 for data integration. The MCOs used an NCQA-certified measure vendor for data production and rate calculation.

Results for Performance Measures

Table 2-3—Nebraska MCO Performance—CMS Adult and Child Core Set Measurement Year (MY) 2022

Performance Measures	HBN	NTC	UHCCP
CMS Adult Core Set Measures			
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	32.48%	57.44%	46.94%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 18 to 64**	1.98%	1.89%	4.44%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+**	5.00%	0.00%	3.69%
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 18 to 64[1]	—	—	—
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 65+[1]	—	—	—
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 18 to 64**	18.27%	18.43%	22.34%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 65+**	10.53%	16.18%	19.73%
CMS Child Core Set Measures			
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 1 Year	33.58%	25.89%	28.69%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 2 Years	37.23%	32.80%	37.98%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 3 Years	31.39%	28.61%	31.89%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	34.06%	29.05%	32.94%
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17[1]	—	—	—
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Most or moderately effective contraception (MMEC)—within 3 days of delivery	1.53%	1.98%	1.91%

Performance Measures	HBN	NTC	UHCCP
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—MMEC—within 90 days of delivery	35.88%	40.48%	50.24%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Long-acting reversible method of contraception (LARC)—within 3 days of delivery	0.00%	1.59%	0.96%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—LARC—within 90 days of delivery	18.32%	20.63%	23.92%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—MMEC	26.07%	28.50%	26.68%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—LARC	4.30%	4.70%	4.29%

[1] The CMS Adult and Child Core Set measures *CDF-AD* and *CDF-CH* were purposely excluded from the template DHHS supplied to the MCOs for Core Measure reporting. The MCOs did not report on these measures for the MY 2022 period.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year(s).

Table 2-4—Nebraska MCO Performance and Statewide Weighted Averages—HEDIS MY 2022

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
Effectiveness of Care: Prevention and Screening				
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile—Total	66.91% ★	70.80% ★	68.37% ★	68.63%
Counseling for Nutrition—Total	68.13% ★★	65.69% ★★	66.67% ★★	66.86%
Counseling for Physical Activity—Total	64.72% ★★	67.64% ★★	66.91% ★★	66.40%
CIS: Childhood Immunization Status				
Combination 3	68.37% ★★★	71.29% ★★★★	77.37% ★★★★★	72.32%
Combination 7	60.83% ★★★★	63.26% ★★★★	69.10% ★★★★★	64.38%
Combination 10	43.80% ★★★★	42.82% ★★★★	53.77% ★★★★★	46.85%
IMA: Immunizations for Adolescents				
Combination 1 (Meningococcal, toxoids and acellular pertussis [Tdap])	81.51% ★★★	78.35% ★★	82.00% ★★★	80.72%
Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	29.44% ★★	27.49% ★	37.47% ★★★	31.68%

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
LSC: Lead Screening in Children				
Lead Screening in Children	69.10% ★★★	68.15% ★★★	73.48% ★★★★	70.28%
BCS: Breast Cancer Screening				
Breast Cancer Screening	44.95% ★	54.65% ★★★	62.86% ★★★★	56.46%
CCS: Cervical Cancer Screening				
Cervical Cancer Screening	57.11% ★★★	61.80% ★★★★	60.58% ★★★	59.86%
CHL: Chlamydia Screening in Women				
Ages 16 to 20	29.27% ★	31.45% ★	27.04% ★	29.17%
Ages 21 to 24	40.85% ★	42.16% ★	38.59% ★	40.48%
Total	34.00% ★	36.07% ★	31.90% ★	33.92%
Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Pharyngitis				
Ages 3 to 17	71.96% ★	69.03% ★	69.34% ★	70.07%
Ages 18 to 64	64.10% ★★	63.02% ★★	63.66% ★★	63.58%
Ages 65+	NA	NA	NA	42.42%
Total	69.55% ★★	67.15% ★★	67.52% ★★	68.04%
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	15.71% ★	28.03% ★★★★	28.57% ★★★★	25.42%
PCE: Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	54.90% ★	72.50% ★★★	72.62% ★★★	68.20%
Bronchodilator	64.71% ★	82.50% ★★	86.43% ★★★	80.10%
AMR: Asthma Medication Ratio				
Ages 5 to 11	80.00% ★★★	82.67% ★★★★	74.43% ★★	78.69%

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
Ages 12 to 18	66.77% ★★	74.78% ★★★★	74.95% ★★★★	72.88%
Ages 19 to 50	67.69% ★★★★	72.22% ★★★★★	68.01% ★★★★	69.26%
Ages 51 to 64	73.50% ★★★★	75.81% ★★★★★	64.32% ★★★	69.66%
Total	71.23% ★★★★	75.92% ★★★★★	70.97% ★★★★	72.63%
Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure				
Controlling High Blood Pressure	69.10% ★★★★	67.64% ★★★★	76.40% ★★★★★	71.95%
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	79.49% ★★	87.23% ★★★★	76.92% ★★	81.16%
Effectiveness of Care: Diabetes				
HBD: Hemoglobin A1c (HbA1c) Control for Patients With Diabetes				
HbA1c Control (<8.0%)	47.69% ★★	52.07% ★★	60.10% ★★★★	54.32%
*HbA1c Poor Control (>9.0%)**	41.61% ★★	36.74% ★★★	29.44% ★★★★★	34.95%
BPD: Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control (<140/90 mm Hg)	71.05% ★★★★	69.59% ★★★	76.16% ★★★★★	72.88%
EED: Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	52.55% ★★★	58.39% ★★★	65.69% ★★★★★	59.90%
Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management				
Effective Acute Phase Treatment	56.05% ★★	62.14% ★★★	64.46% ★★★	61.22%
Effective Continuation Phase Treatment	41.84% ★★	45.37% ★★★	47.48% ★★★	45.12%
ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication				
Initiation Phase	44.62% ★★★	43.99% ★★	48.05% ★★★	45.61%
Continuation and Maintenance Phase	53.01% ★★★★	54.15% ★★★★	55.04% ★★★★	54.10%

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
FUH: Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17	53.20% ★★★	60.04% ★★★★	53.06% ★★★	55.37%
30-Day Follow-Up—Ages 6 to 17	73.73% ★★★	78.59% ★★★★	76.12% ★★★★	76.15%
7-Day Follow-Up—Ages 18 to 64	33.81% ★★★	35.06% ★★★	38.88% ★★★	36.05%
30-Day Follow-Up—Ages 18 to 64	52.69% ★★★	54.78% ★★★	60.96% ★★★	56.36%
7-Day Follow-Up—Ages 65+	NA	NA	NA	35.00%
30-Day Follow-Up—Ages 65+	NA	NA	NA	52.50%
7-Day Follow-Up—Total	39.58% ★★★	42.09% ★★★	42.74% ★★★	41.54%
30-Day Follow-Up—Total	58.97% ★★★	61.43% ★★★	65.04% ★★★	61.97%
FUM: Follow-Up After Emergency Department (ED) Visit for Mental Illness				
7-Day Follow-Up—Total	38.43% ★★	39.42% ★★	37.42% ★★	38.37%
30-Day Follow-Up—Total	56.60% ★★★	59.61% ★★★	59.43% ★★★	58.64%
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)				
7-Day Follow-Up—Total	24.53% ★★	29.56% ★★	23.27% ★★	25.71%
30-Day Follow-Up—Total	42.18% ★★	47.50% ★★	43.54% ★★	43.47%
FUA: Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total	24.34% NC	29.34% NC	31.07% NC	28.41%
30-Day Follow-Up—Total	38.01% NC	43.47% NC	48.22% NC	43.47%
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.52% ★★★	79.60% ★★★	82.26% ★★★	80.68%

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	58.73% ★	61.82% ★	77.41% ★★★★★	70.22%
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	80.56% ★★★	80.00%
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.58% ★	61.39% ★★★	75.58% ★★★★★	66.39%
Effectiveness of Care: Overuse/Appropriateness				
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.21% ★★★	0.48% ★★	0.46% ★★	0.39%
URI: Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	90.77% ★	89.72% ★	90.71% ★	90.41%
Ages 18 to 64	83.23% ★★★	81.86% ★★★	80.97% ★★	81.97%
Ages 65+	NA	NA	65.79% ★★★	69.49%
Total	89.38% ★★	88.04% ★	88.58% ★★	88.67%
LBP: Use of Imaging Studies for Low Back Pain				
Total	74.53% NC	74.09% NC	73.27% NC	73.94%
HDO: Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	2.06% ★★★	2.04% ★★★	4.15% ★★★	3.01%
Access/Availability of Care				
IET: Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment—Total—Ages 13 to 17	28.22% NC	29.91% NC	34.09% NC	30.71%
Engagement of SUD Treatment — Total—Ages 13 to 17	12.33% NC	12.25% NC	12.50% NC	12.36%

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
Initiation of SUD Treatment—Total—Ages 18 to 64	35.99% NC	39.97% NC	36.68% NC	37.59%
Engagement of SUD Treatment—Total—Ages 18 to 64	10.85% NC	12.62% NC	11.14% NC	11.56%
Initiation of SUD Treatment—Total—Ages 65+	25.37% NC	NA	44.27% NC	39.23%
Engagement of SUD Treatment—Total—Ages 65+	7.46% NC	NA	5.34% NC	6.22%
Initiation of SUD Treatment—Total—Total	34.88% NC	38.98% NC	36.70% NC	36.88%
Engagement of SUD Treatment—Total—Total	10.95% NC	12.57% NC	11.05% NC	11.53%
PPC: Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.56% ★	83.45% ★★	86.62% ★★★	83.26%
Postpartum Care	78.59% ★★★	79.08% ★★★	83.45% ★★★★	80.42%
Utilization[1]				
W30: Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	63.05% ★★★	67.06% ★★★★	65.93% ★★★★	65.33%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.63% ★★★	70.09% ★★★	66.66% ★★	68.07%
AMB: Ambulatory Care (Per 1,000 Member Months)				
*ED Visits—Total^**	568.00 ★★★	641.26 ★★	569.46 ★★★	591.37
*Outpatient Visits—Total^*	3,928.06 NC	4,312.27 NC	4,183.68 NC	4,140.37
IPU: Inpatient Utilization—General Hospital/Acute Care				
*Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^*	67.10 NC	69.52 NC	63.22 NC	66.45
Average Length of Stay—Total Inpatient—Total All Ages	5.50 NC	5.44 NC	5.36 NC	5.43
*Discharges per 1,000 Member Months—Maternity—Total All Ages^*	39.30 NC	38.41 NC	31.07 NC	36.00

Performance Measures	HBN	NTC	UHCCP	MY 2022 MCO Weighted Average
Average Length of Stay—Maternity—Total All Ages	2.56 NC	2.65 NC	2.43 NC	2.55
*Discharges per 1,000 Member Months—Surgery—Total All Ages^*	15.10 NC	16.37 NC	14.63 NC	15.33
Average Length of Stay—Surgery—Total All Ages	10.98 NC	10.51 NC	9.23 NC	10.22
*Discharges per 1,000 Member Months—Medicine—Total All Ages^*	26.63 NC	27.68 NC	27.84 NC	27.40
Average Length of Stay—Medicine—Total All Ages	5.20 NC	5.01 NC	5.51 NC	5.25
Risk Adjusted Utilization				
PCR: Plan All-Cause Readmissions				
*Observed Readmissions—Total**	12.41% NC	11.61% NC	8.39% NC	10.93%
*Expected Readmissions—Total**	10.55% NC	10.83% NC	10.92% NC	10.76%
*Observed to Expected (O/E) Ratio—Total**	1.18 ★	1.07 ★	0.77 ★★★★★	1.02
Measures Collected Using Electronic Clinical Data Systems				
BCS-E: Breast Cancer Screening				
Breast Cancer Screening	—	54.41% NC	62.67% NC	60.03%

[1] In the Utilization domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for informational purposes only.
* For this indicator, a lower rate indicates better performance.
^ For this indicator, the rate is reported per 1,000 member months rather than a percentage.
NA indicates that the MCO(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2022 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO(s).
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 2-5—Nebraska DBM Performance—MY 2022

Performance Measures	MCNA MY 2022 Rates
Annual Dental Visit	
The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.	46.92%
The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.	65.32%
The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.	69.19%
The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.	60.54%
The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.	49.20%
The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.	30.56%
The percentage of members 2–20 years of age who had at least one dental visit during the measurement year	57.09%
Prevention: Topical Fluoride for Children	
The percentage of enrolled children aged 1–21 years who received at least two topical fluoride applications within the reporting year (Rate 1).[1]	23.49%
Utilization of Services, Dental Services	
The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.	52.19%
Treatment Services, Dental Service	
The percentage of enrolled children who received a treatment service within the reporting year.	18.19%
Oral Evaluation, Dental Services	
The percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.	48.35%
Care Continuity, Dental Services	
The percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	38.34%

[1] The Dental Quality Alliance (DQA) specifications for the *Prevention: Topical Fluoride for Children* measure approved by DHHS for MY 2022 reporting do not include the additional requirement that the member be at "elevated risk for caries." The DQA specifications for this measure approved by DHHS for MY 2021 reporting include the "elevated risk" requirement.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Performance Measure Rates and Validation

HEDIS Statewide Conclusions, Opportunities for Improvement, and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*, and *Lead Screening in Children* measure indicators were a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid Health Maintenance Organization (HMO) HEDIS MY 2022 75th percentile benchmark for the *Childhood Immunization Status—Combination 7* and *Combination 10* measure indicators, while all three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for the *Childhood Immunization Status—Combination 3* measure indicator and the *Lead Screening in Children* measure. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. In addition, the *Lead Screening in Children* rates demonstrate that children under 2 years of age were adequately receiving a lead blood testing to ensure they were maintaining limited exposure to lead. **[Quality, Timeliness, and Access]**

The MCOs ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for the following measure indicators:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* **[Quality]**
- *Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24,* and *Total* **[Quality]**

Monitoring the weight of children and adolescents can reduce the risk for obesity and prevent adverse health outcomes. Additionally, screening adolescent and adult women can help identify chlamydia infections which, if untreated, can lead to serious and irreversible complications, including pelvic inflammatory disease (PID), infertility, and increased risk of becoming infected with human immunodeficiency virus-1 (HIV-1). HSAG recommends that DHHS work with the MCOs to determine whether children and adolescent members receive a weight assessment and education on healthy habits during visits with a primary care provider (PCP). HSAG also recommends that DHHS determine if the MCOs are following up annually with sexually active members through various modes of communication such as emails, phone calls, or text messages to ensure members return for yearly screening. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 19 to 50*, *Ages 51 to 64*, and *Total* measure indicators were a strength for all three MCOs. All three MCOs' ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for the measure indicators. The rates for

these measure indicators demonstrate that the MCOs were effectively managing this treatable condition for members with persistent asthma. **[Quality]**

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for all three MCOs. All three MCOs ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. Proper testing for pharyngitis helps determine the cause of the infection (i.e., viral or bacterial), allowing for the appropriate use of antibiotic treatment. HSAG recommends DHHS work with the MCOs to ensure that members 3 to 17 years old are properly tested before receiving antibiotics to treat pharyngitis. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for this measure. The rates for this measure demonstrate that the MCOs were effective in helping members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality and Timeliness]**

Effectiveness of Care: Diabetes Domain

The *Blood Pressure Control for Patients With Diabetes* and *Eye Exam for Patients With Diabetes* measures were a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for both measures. The *Blood Pressure Control for Patients With Diabetes* rates demonstrate that the MCOs were effective in helping adult members with diabetes adequately control their blood pressure. In addition, the *Eye Exam for Patients With Diabetes* rates demonstrate that the MCOs were effective in ensuring that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for the following measure indicators:

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* **[Quality, Timeliness, and Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total)* and *30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total)* **[Quality, Timeliness, and Access]**
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**

The *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* rates demonstrate that the MCOs were effective in ensuring that children prescribed ADHD medication participated in timely initial and continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that the MCOs were effective in ensuring the members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* rates demonstrate that the MCOs properly managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Lastly, members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rates demonstrate that the MCOs were effective in ensuring that adult members on antipsychotics were screened for diabetes, resulting in positive health outcomes for this population. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Opioids at High Dosage* measure was a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for the measure. The rates for this measure indicate that the MCOs effectively prevented or minimized the prescribing of opioids at a dosage of ≥ 90 mg morphine equivalent dose. **[Quality]**

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for all three MCOs. All three MCOs' rates for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. The rates for this measure indicator show that a diagnosis of upper respiratory infection (URI) resulted in an antibiotic dispensing event for more members in comparison to the national benchmark. The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommends that DHHS conduct a root cause analysis to ensure the MCOs are aware of appropriate treatments for URI, and that MCO providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

The *Prenatal and Postpartum Care—Postpartum Care* measure indicator was a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The rates for this measure indicator demonstrate that the MCOs were effective in ensuring that members receive timely and adequate postpartum care, in alignment with guidance provided by the American Academy of Pediatrics (AAP)

and the American College of Obstetricians and Gynecologists (ACOG). **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator was a strength for all three MCOs. All three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The rates for this measure indicator demonstrate that the MCOs were effective in ensuring that children were seen by a primary care physician (PCP) within the first 15 months of life to assess and influence members' early development. **[Quality and Access]**

Risk Adjusted Utilization Domain

When conducting the PMV, HSAG did not identify any common strengths or opportunities for improvement across the three MCOs within the *Risk Adjusted Utilization* domain.

Measures Collected Using Electronic Clinical Data System Domain

When conducting the PMV, HSAG did not identify any common strengths or opportunities for improvement across the three MCOs within the *Measures Collected Using ECDS* domain.

DBM Conclusions, Opportunities for Improvement, and Recommendations

HSAG's review of the information provided by **MCNA** before and during the virtual review confirmed that the DBM had processes in place to ensure the quality and accuracy of data used in the calculation of performance measure rates. **[Quality]**

MCNA continuously monitored its performance on the oral health measures specified by DHHS and took steps to address HSAG's recommendations from the 2022 PMV activity regarding members' access to dental services. **MCNA**'s efforts to engage with providers and encourage care gap closures have resulted in an improvement in the MY 2022 rate on the *Care Continuity, Dental Services (CCN-CH-A)* measure compared to MY 2021. **[Access]**

Additionally, although not reflected in the MY 2022 rate for the *Annual Dental Visit (ADV)* measure, **MCNA** launched several campaigns to encourage members ages 19 to 20 years to conduct their annual dental visit, including postcard mailings, text message campaigns, targeted outreach by phone, and gift card incentives. **MCNA** anticipates that these efforts will result in an improved MY 2023 rate on the *ADV* measure indicator. HSAG recommends that **MCNA** continue the efforts implemented in MY 2022 to ensure members continue to have timely access to dental services and to monitor the campaigns implemented in MY 2022 to assess their impact. **[Access]**

Assessment of Compliance With Medicaid Managed Care Regulations

In CY 2021–2022, HSAG collaborated with DHHS to design a three-year review cycle. In CY 2023–2024, HSAG reviewed six of the 13 standards (Part 438 Subpart D and QAPI) with which MCEs are required to comply pursuant to 42 CFR Part 438. To assist Nebraska's Medicaid and CHIP MCEs with understanding the Medicaid and CHIP managed care regulations released in May 2016, with revisions released in November 2020, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. MCEs demonstrating less than 100 percent compliance must develop a corrective action plan (CAP) to address each requirement found to not exhibit full compliance.

Results

Table 2-6 displays the statewide average compliance monitoring results and the year that each standard was reviewed.

Table 2-6—Compliance With Regulations—Statewide Trended Performance for MCEs

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**	Year Three (2023–2024)**
Standard Number and Title	**Statewide Average Results**		
Standard I—Enrollment and Disenrollment	97%	100%	
Standard II—Member Rights and Confidentiality	88%		96%
Standard III—Member Information	83%		91%
Standard IV—Emergency and Poststabilization Services	100%	100%	
Standard V—Adequate Capacity and Availability of Services	97%		100%
Standard VI—Coordination and Continuity of Care	100%		100%
Standard VII—Coverage and Authorization of Services	86%		95%
Standard VIII—Provider Selection and Program Integrity	97%	96%	
Standard IX—Subcontractual Relationships and Delegation	81%	88%	
Standard X—Practice Guidelines	100%	100%	
Standard XI—Health Information Systems	100%	100%	
Standard XII—Quality Assessment and Performance Improvement	100%	100%	
Standard XIII—Grievance and Appeal System	78%		97%

* Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Compliance With Regulations

For the MCEs statewide, the following conclusions were identified:

- All four MCEs received 100 percent compliance with two standards reviewed during CY 2023–2024. **[Quality, Timeliness, and Access]**
- All four MCEs received 100 percent compliance with the Adequate Capacity and Availability of Services standard, demonstrating that each MCE maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**
- All four MCEs received 100 percent compliance with the Coordination and Continuity of Care standard, demonstrating the MCEs had processes in place for their care management programs. **[Quality, Timeliness, and Access]**
- Statewide average results improved or remained at full compliance with each of the standards reviewed during CY 2023–2024. **[Quality, Timeliness, and Access]**
- The MCEs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to their Medicaid members. MCE-specific strengths, opportunities for improvement, and recommendations are detailed in *appendices A–D*. **[Quality, Timeliness, and Access]**

For the MCEs statewide, the following opportunities for improvement were identified:

- Three out of the four MCEs received 95 percent compliance or less in the Member Information standard, indicating that members may not be receiving information regarding their rights and protections. **[Access]**
- Two out of four MCEs received 94.7 percent or less in the Coverage and Authorization of Services standard, demonstrating that the MCEs may not have a thorough and comprehensive approach for review, authorization, and denial of services. **[Timeliness and Access]**
- Two out of the four MCEs received 96.2 percent or less in the Grievance and Appeal System standard, demonstrating that the MCEs may not have processes in place for handling member complaints, grievances, and appeals. **[Quality, Timeliness, and Access]**

For the MCEs statewide, the following recommendations were identified:

- Each MCE should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality, Timeliness, and Access]**

Validation of Network Adequacy

This was the second year in which HSAG conducted a full validation of network adequacy in Nebraska. In collaboration with DHHS, HSAG designed and conducted the following activities to assess the adequacy of the MCEs' compliance with program and contract standards for geographic access to care:

- **Network Capacity Analysis**: HSAG compared the number of providers in each MCE-contracted provider network to the number of members enrolled with the MCE. This provider-to-member ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a provider network to deliver services to Medicaid members. Generally, a lower ratio is more favorable for members, resulting in less competition for access to providers' limited availability and attention. The ratios are provided here for informational purposes only.
- **Geographic Network Distribution Analysis**: HSAG evaluated the geographic distribution of the MCEs' contracted providers relative to their member populations. The MCEs are contractually obligated to maintain a robust provider network accessible to 100 percent of Heritage Health members (unless otherwise specified), within geographic access standards established by DHHS. For most provider categories, the standard requires a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier.) For hospitals, all members statewide must have a hospital within 30 minutes of travel time. For each MCE, HSAG calculated the percentage of members with the required access to network providers to evaluate whether the MCE met the geographic access standards. In addition, HSAG calculated the average travel time (minutes) and distance (miles) from each member to the nearest two providers for each MCE and provider category for informational purposes only.

Results

Network Capacity Analysis

Table 2-7 presents the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for each MCE. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for obstetrics and gynecology (OB/GYN) were limited to female members 15 years of age and older.

Table 2-7—Statewide Population of Eligible Members for MCEs

Member Population	HBN	NTC	UHCCP	MCNA
Children 18 Years and Younger	68,310	65,670	67,173	201,153
Females 15 Years and Older	44,449	47,246	45,836	NA
All Members*	130,937	131,021	131,061	393,019

*"All Members" may not equal the sum of "Children 18 Years and Younger" and "Females 15 Years and Older" as the latter categories overlap and do not include adult males. In addition, "All Members" includes members whose age was not known.
NA—Not applicable.

Table 2-8 and Table 2-9 display the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for the MCOs and **MCNA**, respectively.

Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. Less variation is expected within provider categories assuming that the MCEs have member populations with similar needs. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table 2-8—Statewide Network Capacity Analysis Results for MCOs*

Provider Category	HBN		NTC		UHCCP	
	Providers	Ratio**	Providers	Ratio**	Providers	Ratio**
PCPs	4,320	1:31	2,365	1:56	1,760	1:75
High-Volume Specialists* **						
• Cardiologists	250	1:524	340	1:386	157	1:835
• Neurologists	210	1:624	298	1:440	85	1:1,542
• OB/GYNs	355	1:126	291	1:163	167	1:275
• Oncologists/Hematologists	114	1:1,149	82	1:1,598	67	1:1,957
• Orthopedics	283	1:463	320	1:410	147	1:892
Pharmacies	97	1:1,350	415	1:316	311	1:422
Behavioral Health Inpatient and Residential Service Providers	6	1:21,823	19	1:6,896	5	1:26,213
Behavioral Health Outpatient Assessment and Treatment Providers	2,691	1:49	3,227	1:41	1,289	1:102
Hospitals	140	1:936	81	1:1,618	69	1:1,900

* Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older.

***High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table 2-9—Statewide Network Capacity Analysis Results for MCNA*

Provider Category	MCNA	
	Providers	Ratio**
General Dentists	569	1:691
Oral Surgeons	18	1:21,835
Orthodontists	30	1:13,101
Periodontists	16	1:24,564
Pediadontists	55	1:3,658

* Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** In calculating the ratios, all covered members were considered except in the case of pediadontists (pediatric dentists), where the member population was limited to members 18 years of age and younger.

Geographic Network Distribution Analysis

DHHS has set geographic access standards that require a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier.) As mentioned previously, the exception is for access to hospitals, for which the standard is defined in terms of a maximum travel time (30 minutes) from the member's residence.

MCO Adherence to Time-Distance Standards

Table 2-10 displays the percentage of each MCO's members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results were reported statewide.

Table 2-10—Percentage of Members With Required Access to Care by Provider Category, Urbanicity, and MCO*

		HBN	NTC	UHCCP
Provider Category	Urbanicity**	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
PCPs	Urban	>99.9%	>99.9%	>99.9%
	Rural	100.0%	100.0%	100.0%
	Frontier	100.0%	100.0%	100.0%

Provider Category	Urbanicity**	HBN Percentage of Members With Required Access	NTC Percentage of Members With Required Access	UHCCP Percentage of Members With Required Access
High-Volume Specialists* **				
• Cardiologists	Statewide	>99.9%	>99.9%	>99.9%
• Neurologists	Statewide	>99.9%	100.0%	99.7%
• OB/GYNs	Statewide	>99.9%	99.9%	99.6%
• Oncologists/Hematologists	Statewide	99.5%	99.5%	99.5%
• Orthopedics	Statewide	>99.9%	100.0%	99.6%
Pharmacies	Urban (90%)	88.8%	96.0%	95.2%
	Rural (70%)	39.6%	90.3%	83.1%
	Frontier (70%)	80.3%	97.6%	98.3%
Behavioral Health Inpatient and Residential Service Providers	Urban	100.0%	100.0%	100.0%
	Rural	100.0%	100.0%	100.0%
	Frontier	100.0%	100.0%	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	>99.9%	>99.9%	>99.9%
	Rural	100.0%	>99.9%	99.8%
	Frontier	99.6%	97.8%	97.7%
Hospitals	Statewide	99.0%	96.1%	80.8%

* Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific urbanicity.

** The minimum access is required for 100 percent of members unless otherwise noted.

*** High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

The State of Nebraska is divided into six Behavioral Health Regions, each comprising several counties which collaborate in planning service implementation for behavioral health in their area. For that reason, access to behavioral health services were also examined by region, using the same distance standards. Table 2-11 displays the percentage of each MCO's members with the access to care required by contract standards for behavioral health categories for the MCOs by region.

Table 2-11—Percentage of Members With Required Access to Behavioral Health Services by Provider Category, Region, and MCO*

Region	HBN	NTC	UHCCP
	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers			
Region 1	100.0%	100.0%	100.0%
Region 2	100.0%	100.0%	100.0%
Region 3	100.0%	100.0%	100.0%
Region 4	100.0%	100.0%	100.0%
Region 5	100.0%	100.0%	100.0%
Region 6	100.0%	100.0%	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers			
Region 1	100.0%	100.0%	100.0%
Region 2	99.8%	98.4%	98.3%
Region 3	100.0%	100.0%	>99.9%
Region 4	100.0%	>99.9%	99.7%
Region 5	100.0%	100.0%	100.0%
Region 6	100.0%	100.0%	100.0%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.

DBM Adherence to Geographic Access Standards

Table 2-12 displays the percentage of members with the access to care required by geographic access standards for all applicable provider categories and urbanicities for **MCNA**.

Table 2-12—Percentage of Members With Required Access to Dental Care by Provider Category and Urbanicity*

Provider Category	Urbanicity	MCNA
		Percentage of Members Within Standard
General Dentists	Urban	100.0%
	Rural	>99.9%
	Frontier	100.0%
Oral Surgeons	Urban	87.0%
	Rural	62.6%
	Frontier	21.3%

Provider Category	Urbanicity	MCNA Percentage of Members Within Standard
Orthodontists	Urban	93.4%
	Rural	73.1%
	Frontier	85.0%
Periodontists	Urban	74.7%
	Rural	37.1%
	Frontier	0.0%
Pediadontists/Pedodontists	Urban	99.5%
	Rural	82.5%
	Frontier	86.9%

*Red cells indicate that minimum geographic access standards were not met by **MCNA** for a specific provider category in a specific urbanicity.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Network Adequacy

Overall, the Nebraska CY 2023–2024 NAV results suggest that the MCEs have comprehensive provider networks. Nebraska's MCEs have generally contracted with a variety of providers to ensure that members have access to a broad range of health care services within geographic time/distance standards. There are some opportunities for improvement, particularly in certain geographic areas and for certain provider categories (i.e., pharmacies and dental specialists).

For the MCEs statewide, the following conclusions were identified:

- Network Capacity Analysis
  - For access to PCPs, ratios ranged from a low of one PCP per 31 members (**HBN**) to a high of one PCP per 75 members for **UHCCP**. As expected, the ratios among high-volume specialists were much more variable. All plans provided members with the lowest ratios for OB/GYN providers with 1:126 for **HBN**, 1:163 for **NTC**, and 1:275 for **UHCCP**. The highest ratios were for access to oncologists/hematologists, with one provider per 1,149 for members for **HBN**, one per 1,598 members for **NTC**, and one per 1,957 members for **UHCCP**. Across all five types of high-volume specialists, **UHCCP** maintained the highest ratios, with the greatest number of members per provider, sometimes by a large margin. **[Access]**
  - For access to facilities (i.e., pharmacies and hospitals), **HBN** had the highest provider ratio for pharmacies, with one pharmacy per 1,350 members, compared to one per 316 members for **NTC** and one per 422 members for **UHCCP**. **UHCCP** had the highest ratio for hospitals (1:1,900) but was closely followed by **NTC** (1:1,618), whereas the ratio was considerably lower for **HBN** (1:936). **[Access]**

  - For access to behavioral health providers, **NTC** identified more inpatient and residential service providers (19) than either of the other MCOs, with six for **HBN** and five for **UHCCP**. **NTC**'s provider ratio was therefore much lower at 1:6,896 compared to ratios of 1:21,823 for **HBN** and 1:26,213 for **UHCCP**. The variation in provider ratios was much narrower for behavioral health outpatient assessment and treatment providers, with **HBN** at 1:49, **NTC** at 1:41, and **UHCCP** at 1:102. **[Access]**
  - For access to dental providers, **MCNA**'s ratio for general dentists (one per 691 members) was much lower than for any other dental provider categories, including pediatric dentists (pediadontists: one per 3,658 enrolled children 18 years of age and younger). All other dental provider categories had provider ratios higher than one provider per 10,000 members. **[Access]**
- Geographic Network Distribution Analysis
  - Of the 18 provider category/urbanicity combinations across all MCOs in Table 2-10, **HBN** met seven geographic access standards, **NTC** met 10 standards, and **UHCCP** met eight standards. Nonetheless, the percentage of members with access to providers in compliance with the geographic access standards across all MCOs, provider categories, and urbanicities was generally above 99 percent. Across all provider categories with a 100 percent geographic access standard (i.e., all but pharmacies), only one MCO met access standards for less than 90 percent of its members in any provider category/urbanicity combination (80.8 percent of **UHCCP** members had the required access to a hospital within 30 minutes). For pharmacies, **HBN** failed to meet standards by 1.2 percentage points in urban counties and by 30.4 percentage points in rural counties. Only 39.6 percent of **HBN** members in rural counties had the required access to a pharmacy, far below the required 70 percent. Both **NTC** and **UHCCP** met the standards for pharmacies in all urbanicities. **[Access]**
  - **MCNA**'s network met geographic access standards for general dentists in urban and frontier counties, and narrowly failed to meet the standard in rural counties by less than 0.1 percentage points. **MCNA** also achieved a high level of access to pediadontists in urban counties, with 99.5 percent of members having a provider within the required 45 miles. However, standards were not met in any urbanicity for pediadontists or for any of the dental specialty provider categories. The three greatest deficits in access were for periodontists in rural counties (37.1 percent with access within 60 miles) and frontier counties (no members with access within 100 miles), and oral surgeons in frontier counties (21.3 percent of members with access within 100 miles). For all other specialties, at least 60 percent of members had access to care within the geographic access standards. **[Access]**

For the MCEs statewide, the following opportunities for improvement were identified:

- Within the Geographic Network Distribution Analysis, there are opportunities for improvement, particularly with statewide access to dental specialists and access to behavioral health outpatient assessment and treatment providers in Behavioral Health Region 2 and to a lesser extent in Regions 3 and 4. **[Access]**

For the MCEs statewide, the following recommendations were identified:

- For the provider categories for which each MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.

Overall Heritage Health Program Conclusions

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCE, as well as the program overall. To produce Nebraska's CY 2023–2024 technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCEs:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each MCE to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by the MCE for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and accessibility of care and services furnished by the MCE.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, quality, timeliness, and accessibility of care and services furnished by the MCE.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Table 2-13 provides the overall strengths and weaknesses of the Heritage Health Program that were identified as a result of the EQR activities.

Table 2-13—Overall Heritage Health Program Conclusions: Quality, Timeliness, and Access

Overall Program Strengths	
Domain	**Conclusion**
Quality, Timeliness, and Access	The Heritage Health Program's MCEs are largely in compliance with federal and State managed care requirements. Overall, the MCEs are performing well. When deficiencies were identified, the MCEs responded with corrective actions, demonstrating their commitment to quality improvement.
	The MCOs performed at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark in four of the measures in the behavioral health domain. This demonstrated strong performance in the Behavioral Health domain.

Overall Program Strengths	
Domain	**Conclusion**
	The MCOs performed at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for *Childhood Immunization Status—Combination 7* and *Combination 10* measure indicators and for *Controlling High Blood Pressure*. This demonstrated strong performance in the Prevention and Screening and Cardiovascular Conditions domains.
Quality	DHHS has effectively managed oversight and collaboratively worked with the MCEs and the EQRO to ensure successful program operations and performance monitoring.
	Overall, Heritage Health Program's MCEs demonstrated sound reporting, methodology, and barrier analysis for PIPs.
	The DBM has processes in place to ensure the quality and accuracy of data used in the calculation of performance measure rates.
Timeliness and Access	The Heritage Health Program's MCEs largely have comprehensive provider networks and generally contract with a variety of providers to ensure that members have access to a broad range of health care services within time/distance standards.
Overall Program Weaknesses	
Domain	**Conclusion**
Quality	The MCOs ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for the following measure indicators: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* • *Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24,* and *Total* • *Appropriate Testing for Pharyngitis—Ages 3 to 17* • *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*
Timeliness and Access	There are opportunities for improvement for statewide access to dental specialists and access to behavioral health outpatient assessment and treatment providers.

Nebraska DHHS Quality Strategy for Heritage Health Program

In accordance with 42 CFR §438.340, DHHS implemented a written quality strategy for assessing and improving the quality of health care services furnished by the MCEs to Nebraska Medicaid members under the Heritage Health Program.

MLTC engages with all contracted MCEs to support their quality initiatives and to help align these interventions with those described in the 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 meetings to

consult on difficult-to-place patients, high-cost claimants, and medically/behaviorally complex patients. MLTC performs in-depth compliance oversight to ensure that contractual standards for its 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 the updated quality strategy, the 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 the quality strategy and to make updates when evaluations point toward an approach that may be more impactful on quality improvement. MLTC will annually review all quality metrics in order to assess progress toward performance targets.

Goals and Objectives

The goals and objectives for the Heritage Health Program, described in Table 2-14, directly reflect the Quadruple Aim of improving member experience of care, provider experience of care, and the health of populations, as well as ensuring the long-term financial viability of the Medicaid program.

Table 2-14—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 non-emergency medical transportation 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 decision making.	Engage with enrollees to improve enrollee experience and outcomes and increase public awareness about services.

Aim	Goal	Objective
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 credentialing by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialing 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.

Aim	Goal	Objective
Reduce the Per Capita Cost of Health Care 	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 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 incentive innovation.	Incorporate into Heritage Health contracts incentives for improving health outcomes.

Recommendations for the Nebraska DHHS Quality Strategy for Heritage Health Program

HSAG's EQR results and guidance on actions assist MLTC in evaluating the MCEs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist MLTC and the MCEs in achieving and exceeding goals. In addition to providing each MCE with specific guidance, HSAG offers MLTC the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members. HSAG's specific recommendations are included in Table 2-15.

Table 2-15—Recommendations for Heritage Health Program

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal**
MLTC can support the MCOs in improving performance measure scores that are currently below the NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark by encouraging the MCOs to identify barriers related to these performance measures and to implement interventions targeting these performance measures.	Promote wellness and prevention.
MLTC can support statewide access to dental specialists and access to behavioral health outpatient assessment and treatment providers through expanding telehealth services and working to identify root causes for the lack of access to dental specialists in specific regions.	Expand access to high-quality services to meet the needs of diverse clients.

3. Methodology

This section, requirement §438.364(a)(1), describes the manner in which (1) the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by each MCE.

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving MCE processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each MCE's compliance with requirements set forth in 42 CFR §438.240(b) (1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the MCE conducted during the PIP. HSAG's scoring methodology evaluated whether the MCE executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[3-1] For future validations, HSAG will use

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, February 2023.[3-2] HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCE designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCE improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results). The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCEs with specific feedback and recommendations. The MCEs used a standardized PIP submission form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP submission form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all the critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. The outcome of these calculations determined the validation status of *Met*, *Partially Met*, or *Not Met*.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each MCE. HSAG then identified common themes and the salient patterns that emerged across MCEs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

Using a standardized scoring methodology, HSAG assigned an overall validation status and reported the overall validity and reliability of the findings as one of the following:

- ***Met*** = High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- ***Partially Met*** = Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- ***Not Met*** = Reported findings are not credible. All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

PIPs that accurately addressed CMS EQR protocol requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the study results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was not credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCEs, HSAG assigned each of the components reviewed for PIP validation to one or more of these three domains. While the focus of an MCE's PIP may have been to improve performance related to health care quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCE's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 3-1.

Table 3-1—Assignment of PIPs to the Quality, Timeliness, and Access Domains

MCE	Performance Improvement Project	Quality	Timeliness	Access
HBN	*Plan All-Cause Readmissions*	✓		
HBN	*Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)*	✓	✓	✓
NTC	*Plan All-Cause Readmissions*	✓		
NTC	*Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*	✓	✓	

MCE	Performance Improvement Project	Quality	Timeliness	Access
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	✓		
UHCCP	*Improving the Member Experience with the Health Plan's Member Services*	✓		
MCNA	*First Dental Visit at Age 1*	✓	✓	✓
MCNA	*Increasing the Percentage of Providers Receiving Cultural Competency Training*	✓		

Validation of Performance Measures

Objectives

In accordance with 42 CFR §438.330(c), states must require MCOs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the MCE.
- Determine the extent to which the specific performance measures calculated by the MCE (or on behalf of the MCE) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

MCOs

DHHS required that each MCO undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA LO. CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-3] identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol.

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

Therefore, HSAG requested copies of the FAR for each MCO and aggregated several sources of HEDIS-related data to confirm that the MCOs met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS Compliance Audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[3-4]

- Teleconference calls with the MCO's personnel and vendor representatives, as necessary.
- Detailed review of the MCO's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the MCO's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate MRR data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the determinations of the MCO's MRR contractor for the same records.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS MY 2022 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the MCO and/or its contractor.

The MCOs were responsible for obtaining and submitting their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the MCO's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the MCOs, it did review the audit reports produced by the other LOs. Through review of each MCO's FAR, HSAG determined whether all LOs followed NCQA's methodology in conducting their HEDIS Compliance Audits.

[3-4] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

The DBM

DHHS selected the performance measures for calculation by the DBM, and the DBM completed the calculation of all measures by using a number of data sources, including claims/encounter data and enrollment/eligibility data.

HSAG conducted PMV for the DBM's measure rates. DHHS required that the MY 2022 (i.e., January 1, 2022–December 30, 2022) performance measures be validated during calendar year 2023 based on NCQA, CMS Child Core Set, and American Dental Association (ADA) specifications.

HSAG's process for PMV for the DBM included the following steps.

Pre-Review Activities: Based on the measure definitions and reporting guidelines provided by DHHS, HSAG:

- Developed measure-specific worksheets that were based on the measure specifications and were used to improve the efficiency of validation work performed during the virtual review.
- Developed an Information Systems Capabilities Assessment Tool (ISCAT) that was used to collect the necessary background information on the DBM's IS, policies, processes, and data needed for the virtual performance of validation activities. HSAG included questions to address how encounter data were collected, validated, and submitted to DHHS.
- Reviewed other documents in addition to the ISCAT, including source code for performance measure calculation and supporting documentation.
- Performed other pre-review activities including review of the ISCAT and supporting documentation, scheduling, and preparing the agenda for and scheduling the virtual review, and conducting conference calls with the DBM to discuss the virtual review activities and to address any ISCAT-related questions.

Virtual Review Activities: HSAG conducted a virtual review for the DBM to validate the processes used for calculating rates on performance measures. The virtual review included:

- An opening conference to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- Evaluation of system compliance, including a review of the IS assessment, focusing on the processing of claims, encounters, and member and provider data.
- PSV on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data systems.
- Evaluation of the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- Review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with key DBM staff members, allowed

HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed.

- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for reporting the selected performance measures. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- A closing conference to summarize preliminary findings from the review of the ISCAT and the virtual review, and to revisit the documentation requirements for any post-review activities.

Post-On-Site Review Activities: Following the virtual review, HSAG:

- Received and reviewed additional documentation requested during the virtual on-site review.
- Worked collaboratively to resolve any outstanding items, if applicable.
- Assigned an audit result to each selected measure.
- Produced and provided a FAR containing a summary of all audit activities.

Description of Data Obtained

MCOs

As identified in the HEDIS Compliance Audit methodology, the following key types of data were obtained and reviewed as part of the PMV activity:

1. **FARs:** The FARs, produced by the MCEs' LOs, provided information on the MCEs' compliance to IS standards and audit findings for each measure required to be reported.
2. **Rate Files for the Current Year:** Final rates provided by the MCEs in IDSS format were reviewed to determine trending patterns and rate reasonability.

The DBM

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data as part of the PMV activity:

1. **ISCAT:** This was received from the DBM. The completed ISCAT provided HSAG with background information on the DBM's IS, policies, processes, and data in preparation for the virtual validation activities.
2. **Source Code (Programming Language) for Performance Measures:** This was obtained from the DBM and was used to determine compliance with the performance measure definitions.
3. **Supporting Documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system

flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.

4. **Current Performance Measure Results:** HSAG obtained the results from the measures the DBM calculated.
5. **Virtual Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key DBM staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG collected IDSS files and FARs for MY 2022 from all three MCOs that had been previously audited by a third-party LO. HSAG reviewed the documentation to evaluate the accuracy of the data and to identify any issues of noncompliance or problematic performance measures. HSAG then provided recommendations and conclusions to DHHS based on measure rates falling at or above the 50th or below the 25th performance measure percentiles based on NCQA's HMO Quality Compass HEDIS MY 2022 percentile benchmarks.

HSAG also performed a performance validation audit of the DBM for DHHS' selected measures. HSAG evaluated **MCNA**'s eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the DBM, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by each MCE. HSAG then identified common themes and the salient patterns that emerged across MCEs related to the PMV activity conducted.

How Conclusions Were Drawn

Information Systems Standards Review

The MCEs must be able to demonstrate compliance with IS standards. MCEs' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCE compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[3-5] The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

[3-5] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—MRR Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in *Section 2* and the *appendices*, HEDIS MY 2022 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA LO according to NCQA standards. With regard to the final measure rates for HEDIS MY 2022, a measure result of *Small Denominator* (*NA*) indicates that the MCE followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the MCE chose not to report the measure.

Performance Measure Results

The MCOs' measure results were evaluated based on statistical comparisons.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the specific size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for MCO 1
R_1 = the rate for MCO 1
P_2 = the eligible population for MCO 2
R_2 = the rate for MCO 2

Measure results for HEDIS MY 2022 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCEs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-2. The measures marked *NA* are related to utilization of services.

Table 3-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measures	Quality	Timeliness	Access
Effectiveness of Care: Prevention and Screening			
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	✓		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	✓		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	✓		
CIS: Childhood Immunization Status—Combination 3	✓		✓
CIS: Childhood Immunization Status—Combination 7	✓		✓
CIS: Childhood Immunization Status—Combination 10	✓		✓
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, toxoids and acellular pertussis [Tdap])	✓		
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	✓		
LSC: Lead Screening in Children	✓	✓	
BCS: Breast Cancer Screening	✓		
CCS: Cervical Cancer Screening	✓		
CHL: Chlamydia Screening in Women—Ages 16 to 20	✓		
CHL: Chlamydia Screening in Women—Ages 21 to 24	✓		
CHL: Chlamydia Screening in Women—Total	✓		
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	✓		
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	✓		
CWP: Appropriate Testing for Pharyngitis—Ages 65+	✓		
CWP: Appropriate Testing for Pharyngitis—Total	✓		
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	✓		✓
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	✓	✓	
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	✓	✓	
AMR: Asthma Medication Ratio—Ages 5 to 11	✓		
AMR: Asthma Medication Ratio—Ages 12 to 18	✓		

Performance Measures	Quality	Timeliness	Access
AMR: Asthma Medication Ratio—Ages 19 to 50	✓		
AMR: Asthma Medication Ratio—Ages 51 to 64	✓		
AMR: Asthma Medication Ratio—Total	✓		
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure	✓	✓	
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	
Effectiveness of Care: Diabetes			
HBD: Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Control (<8.0%)	✓		
HBD: HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)	✓		
BPD: Blood Pressure Control for Patients With Diabetes	✓		
EED: Eye Exam for Patients With Diabetes	✓		
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	✓		
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	✓		
ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	✓	✓	✓
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65+	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	✓	✓	✓
FUM: Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total	✓	✓	✓
FUM: Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	✓	✓	✓
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)—7-Day Follow-Up—Total	✓	✓	✓
FUI: Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	✓	✓	✓
FUA: Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total	✓	✓	✓
FUA: Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	✓	✓	✓
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Effectiveness of Care: Overuse/Appropriateness			
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65+	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Total	✓		
LBP: Use of Imaging Studies for Low Back Pain—Total	✓		
HDO: Use of Opioids at High Dosage	✓		
Access/Availability of Care			
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 13 to 17	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 13 to 17	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 18 to 64	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 18 to 64	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 65+	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 65+	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total	✓	✓	✓
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total	✓	✓	✓
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	✓	✓	✓
PPC: Prenatal and Postpartum Care—Postpartum Care	✓	✓	✓
Utilization			
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓		✓
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	✓		✓
AMB: Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total	NA	NA	NA
AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total	NA	NA	NA

Performance Measures	Quality	Timeliness	Access
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total	NA	NA	NA
Risk Adjusted Utilization			
PCR: Plan All-Cause Readmissions—Observed Readmissions—Total	✓		
PCR: Plan All-Cause Readmissions—Expected Readmissions—Total	✓		
PCR: Plan All-Cause Readmissions—Observed to Expected (O/E) Ratio—Total	✓		
Measures Collected Using Electronic Clinical Data Systems			
BCS-E: Breast Cancer Screening	✓		

Table 3-3—Assignment of DBM Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measures	Quality	Timeliness	Access
ADV: Annual Dental Visit—The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.			✓
ADV: Annual Dental Visit—The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.			✓
TFL-CH-A: Prevention: Topical Fluoride for Children—The percentage of enrolled children aged 1–21 years who received at least two topical fluoride applications within the reporting year (Rate 1).	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
UTL-CH-A: Utilization of Services, Dental Services—The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.			✓
TRT-CH-A: Treatment Services, Dental Service—The percentage of enrolled children who received a treatment service within the reporting year.	✓	✓	✓
OEV-CH-A: Oral Evaluation, Dental Services—The percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.			✓
CCN-CH-A: Care Continuity, Dental Services—The percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.			✓

Assessment of Compliance With Medicaid Managed Care Regulations

Table 3-4 delineates the compliance review activities as well as the standards that were reviewed during the current three-year compliance review cycle. CAPs from findings during the 2022 compliance reviews were evaluated and resolved in 2023.

Table 3-4—Summary of Compliance Standards and Associated Regulations

	Year One (2021–2022)	Year Two (2022–2023)	Year Three (2023–2024)
Standard	**Review of Standards**		
Standard I—Enrollment and Disenrollment	✓	✓	
Standard II—Member Rights and Confidentiality	✓		✓
Standard III—Member Information	✓		✓
Standard IV—Emergency and Poststabilization Services	✓	✓	
Standard V—Adequate Capacity and Availability of Services	✓		✓
Standard VI—Coordination and Continuity of Care	✓		✓
Standard VII—Coverage and Authorization of Services	✓		✓
Standard VIII—Provider Selection and Program Integrity	✓	✓	
Standard IX—Subcontractual Relationships and Delegation	✓	✓	
Standard X—Practice Guidelines	✓	✓	
Standard XI—Health Information Systems	✓	✓	
Standard XII—Quality Assessment and Performance Improvement	✓	✓	

	Year One (2021–2022)	Year Two (2022–2023)	Year Three (2023–2024)
Standard	**Review of Standards**		
Standard XIII—Grievance and Appeal System	✓		✓

HSAG divided the federal regulations into 13 standards consisting of related regulations and contract requirements. Table 3-5 describes the standards and associated regulations and requirements reviewed for each standard.

Table 3-5—Summary of Compliance Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection and Program Integrity	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems*	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal System	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	* Requirement §438.242: Validation of IS standards for each MCE was conducted under the PMV activity.	

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to DHHS and the MCEs regarding:

- The MCEs' compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCEs into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care furnished by the MCEs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCEs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the MCEs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[3-6] Table 3-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 3-6—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DHHS contract requirements: • HSAG and DHHS collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted monitoring tools, report templates, and agendas, and sent review dates to DHHS for review and approval. • HSAG forwarded the monitoring tools and agenda to the MCEs. • HSAG conducted training for all reviewers to ensure consistency in scoring across the MCEs. • HSAG scheduled the virtual reviews and distributed the agendas to the MCEs to facilitate preparation for the reviews.

[3-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

For this protocol activity,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCE training webinar to describe HSAG's processes and allow the MCEs the opportunity to ask questions about the review process and MCE expectations. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate. • No less than 60 days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. No less than 30 days prior to the scheduled review, the MCE provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCE Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics, for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2023–2024 DHHS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • HSAG analyzed the findings and calculated final scores based on DHHS-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.

For this protocol activity,	HSAG completed the following activities:
Activity 5:	**Report Results to DHHS**
	• HSAG populated and submitted the draft reports to DHHS and the MCEs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCE and DHHS.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Interviews with key MCE staff members conducted virtually

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key MCE personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

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

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

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of care furnished by each MCE. HSAG then identified common themes and the salient patterns that emerged across MCEs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MCEs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCEs. Table 3-7 depicts assignment of the standards to the domains of care.

Table 3-7—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard XIII—Grievance and Appeal System	✓	✓	✓

Validation of Network Adequacy

Objectives

HSAG developed and conducted the NAV activities for Heritage Health MCEs during CY 2023–2024. HSAG's NAV analysis continued to build on the work completed in CY 2021–2022 and CY 2022–2023 to assess the MCEs' compliance with established GeoAccess network standards. HSAG conducted analyses to evaluate the accuracy of the MCEs' self-reported compliance with Heritage Health's contract standards for geographic access to care. HSAG conducted the following tasks during CY 2023–2024:

1. Developed and submitted to DHHS a detailed data request for Medicaid member files for members enrolled as of a specific date determined in collaboration with DHHS.

2. Developed and submitted to each MCE a data request for provider network files for providers actively enrolled as of a specific date determined in collaboration with DHHS.
3. Conducted a geographic access analysis to evaluate the compliance of the MCE provider networks with the quality strategy.

The providers included in the NAV analysis consisted of all ordering, referring, and servicing providers contracted to provide care through one of the four MCEs, and for whom a geographic access standard is identified. Additionally, HSAG collaborated with DHHS to define out-of-state providers that may be included in the NAV analysis.

The CY 2023–2024 NAV activities aligned with three general project phases described in Figure 3-1.

Figure 3-1—Summary of NAV Project Phases and Tasks

 **Phase 1: Data Collection**	 **Phase 2: Synthesis & Analysis**	 **Phase 3: Reporting**
Request Data From DHHS • Medicaid member files ***Develop Provider Data Request*** • Draft data request with DHHS' feedback and approval • Distribute data request to the MCEs • Host webinar with the MCEs to review data request and respond to questions	***Evaluate MCEs' Provider Network Data*** • Identify provider networks subject to geographic access standards • Standardize member and provider address data • Perform analysis to evaluate the percentage of members with access to providers within the distance standards and travel time and distance to the nearest three providers • Perform analysis to evaluate member-to-provider ratios	***Report on NAV Results*** • Submit draft report to DHHS • Incorporate DHHS' feedback • Submit final, 508-compliant report to DHHS

Technical Methods of Data Collection

In February 2023, CMS released updates to the EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at §438.358(b)(1)(iv) no later than one year from the issuance of the associated EQR protocol. This means that by February 2024, HSAG will begin conducting NAV activities in accordance with Protocol 4 and will report results in the EQR technical report due April 30, 2025. This report does not incorporate Protocol 4.

DHHS Member Data Request

To conduct the NAV analysis, HSAG requested Medicaid member files from DHHS for use in the CY 2023–2024 NAV. HSAG requested data for members actively enrolled in an MCE as of June 1, 2023. To define the requested data, HSAG submitted a detailed member data requirements document to DHHS and hosted a technical assistance call to review the data request in detail and clarify any questions regarding the data request. The member data requirements document included a template detailing fields to be included, field descriptions, naming conventions, and formats.

Upon receiving the member data files from DHHS, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. Submitted data elements underwent a series of rigorous quality control (QC) examinations to ensure data were representative, complete, and accurate. HSAG provided DHHS with the results of this review and requested resubmission of files as needed.

MCE Provider Data Request

To conduct the NAV analysis, HSAG requested provider data files from the MCEs for providers actively enrolled as of June 1, 2023. To define the requested data, HSAG submitted a detailed provider data requirements document to the MCEs and hosted a technical assistance call to review the data request in detail and clarify any questions regarding the data request.

Upon receiving the MCEs' provider data files, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. Submitted data elements underwent a series of rigorous QC examinations to ensure data were representative, complete, and accurate. HSAG provided the MCEs with the results of the data review, including any questions that need clarification. The MCEs were requested to resubmit files as needed.

Description of Data Obtained

DHHS Member Data

HSAG requested data for members actively enrolled in an MCE as of June 1, 2023, a date determined in collaboration with DHHS. Key data elements requested included, but were not limited to, each member's street address, city, state, ZIP Code, dates of enrollment, and MCE affiliation.

MCE Provider Data

HSAG submitted a detailed data requirements document for the provider data to the MCOs and the DBM for providers actively enrolled as of June 1, 2023, a date identified in collaboration with DHHS. HSAG supplied the MCOs and the DBM with instructions consistent with existing methods for classifying providers into categories for the geographic access analysis. Key data elements that were requested included, but were not limited to, unique provider identifier, enrollment status with the MCOs or DBM, provider type, provider specialty, taxonomy code, and indicator flags to identify different provider categories such as PCPs, high-volume specialists, and dental specialists.

How Data Were Aggregated and Analyzed

HSAG used the Medicaid member files from DHHS and the MCE provider network data to perform the NAV analysis. The NAV analysis evaluated two dimensions of access and availability:

- **Network Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of providers associated with the MCE's provider network relative to the number of enrolled members. This provider-to-member ratio (provider ratio) represented a summary statistic used to highlight the overall capacity of an MCE's provider network to deliver services to Medicaid members.
- **Geographic Network Distribution Analysis:** The second dimension of this study evaluated the geographic distribution of the providers relative to member populations. For each MCE and county, HSAG calculated the percentage of members with the required access as defined in the quality strategy 2020. HSAG also calculated the average travel time (minutes) and distance (miles) from all members to the nearest two providers for each provider type.

Network Capacity Analysis

HSAG calculated the provider ratio for each provider category included in the analysis for the MCEs. Specifically, the provider ratio measured the number of providers by provider category (e.g., PCPs, high-volume specialists, pharmacies, and hospitals) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available[3-7] to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations. Because provider ratio standards were not defined as part of the quality strategy 2020, the results of this analysis were descriptive only and were not intended as an evaluation of the MCEs for meeting or failing to meet specific standards.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to the MCEs' members. While the network capacity analysis identified whether the network infrastructure was sufficient in both number of providers and variety of provider types, the geographic network distribution analysis evaluated whether the provider locations in an MCO's or the DBM's provider network were proportional to their respective Medicaid member population.

To provide a comprehensive view of geographic access, HSAG calculated the following spatially-derived metrics for the provider categories with geographic access standards:

[3-7] The availability based on provider ratio did not account for key practice characteristics—i.e., panel status, acceptance of new patients, or practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

- **Percentage of members with required access according to standards**:[3-8] A higher percentage of members meeting access standards indicates better geographic distribution of an MCO's or the DBM's providers in relation to its Medicaid members. This metric was calculated for any provider categories for which DHHS has identified a geographic access standard prior to initiation of the analysis and ascertained the extent to which each plan was meeting applicable standards.
- **Average travel distance (driving distance in miles) or travel time[3-9] (in minutes) for providers with travel time standards, to the nearest two providers**: A shorter distance or less travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

HSAG used software from Quest Analytics to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to two providers for all provider categories identified in the analysis. All study results were stratified by MCE, as well as by county. Table 3-8 shows the provider categories that were used to assess the MCEs' compliance with the geographic access standards.

Table 3-8—Provider Categories, County Urbanicity, and Geographic Access Standards

Provider Category	County Urbanicity	Geographic Access Standard
MCO Geographic Access Standards		
Primary care providers (adult and pediatric)	Urban	2 providers within 30 miles
	Rural	1 provider within 45 miles
	Frontier	1 provider within 60 miles
High-volume specialists (adult and pediatric)	All counties	1 provider within 90 miles
Pharmacy (adult and pediatric)	Urban	90 percent of members within 5 miles
	Rural	70 percent of members within 15 miles
	Frontier	70 percent of members within 60 miles
Behavioral health inpatient and residential service providers (adult and pediatric)	Rural and Frontier	Sufficient locations to allow members to travel to provider and return home within a single day[1]
Behavioral health outpatient assessment and treatment providers (adult and pediatric)	Urban	Adequate choice within 30 miles[2]
	Rural	2 providers within 45 miles[3]
	Frontier	2 providers within 60 miles[3]

[3-8] The percentage of members within predefined standards was only calculated for provider categories with predefined access standards.

[3-9] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times were estimated by Quest Analytics based on the following drive speeds: urban areas were estimated at a drive speed of 30 miles per hour, suburban areas were estimated at a drive speed of 45 miles per hour, and rural areas were estimated at a drive speed of 55 miles per hour.

Provider Category	County Urbanicity	Geographic Access Standard
Hospitals (adult and pediatric)	All counties	1 hospital within 30 minutes' drive time[4]
DBM Geographic Access Standards		
Dentists (adult and pediatric)	Urban	2 providers within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Oral Surgeons (adult and pediatric)	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Orthodontists (adult and pediatric)	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Periodontist (adult and pediatric)	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Pediadontist (adult and pediatric)	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles

[1] HSAG confirmed with DHHS that this standard should be evaluated as "1 provider within 240 miles" or a 480-mile round trip within a single day.

[2] HSAG collaborated with DHHS to determine that this standard should be evaluated as "2 providers within 30 miles" based on comparable standards in other EQRO states.

[3] If rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must use telehealth options. At the time of this study, DHHS had not determined any rural or frontier county network to be deficient for this provider category.

[4] In rural areas, hospital access time may be greater than 30 minutes. If greater, the standard needs to be the community standard for accessing care, and the exceptions must be justified and documented to the State on the basis of community standards. At the time of this study, DHHS had not identified any rural county wherein usual and customary transport time exceeded 30 minutes.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about MCE performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Nebraska Heritage Health member access to particular provider networks (e.g., primary, specialty, or dental health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCEs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCEs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-9.

Table 3-9—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activities	Quality	Timeliness	Access
Network Capacity Analysis—Provider Ratios			✓
Geographic Network Distribution Analysis—Percentage of Members With Access According to Standards			✓

Validation of Performance Improvement Projects

Results

Clinical PIP: *Plan All-Cause Readmissions*

HBN submitted the clinical PIP, *Plan All-Cause Readmissions*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions* measure, for the CY 2023–2024 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission. **HBN** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table A-1 summarizes **HBN**'s PIP validation scores.

Table A-1—2023–2024 PIP Validation Results for HBN

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Plan All-Cause Readmissions	Initial Submission	81%	89%	*Partially Met*
	Resubmission	90%	100%	*Met*

Overall, 90 percent of all applicable evaluation elements received a score of *Met*. Table A-2 presents baseline, Remeasurement 1, and Remeasurement 2 performance indicator data for **HBN**'s *Plan All-Cause Readmissions* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table A-2—Performance Indicator Results for HBN's *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 150 D: 1,937	7.74%	N: 162 D: 1,542	10.51%	N: 233 D: 2,523	9.24%	*Not Assessed*

N–Numerator, D–Denominator

For the baseline measurement period, **HBN** reported that 7.74 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge.

For the first remeasurement period, **HBN** reported that 10.51 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The increase in the total observed readmission rate of 2.77 percentage points represented a decline in indicator performance from baseline to Remeasurement 1.

For the second remeasurement period, **HBN** reported that 9.24 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The increase of 1.50 percentage points in the total observed readmission rate from baseline to Remeasurement 2 represented a decline in indicator performance compared to initial indicator results.

Nonclinical PIP: *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)*

HBN submitted the nonclinical PIP, *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)*, focused on improving performance in the percentage of members for whom a response of "always" or "usually" was provided for Child CAHPS survey Question 23, "In the last 6 months, how often did you get an appointment for your child with a specialist as soon as he or she needed?" for the CY 2023–2024 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission. **HBN** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Partially Met* validation status. Table A-3 summarizes **HBN**'s PIP validation scores.

Table A-3—2023–2024 PIP Validation Results for HBN

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)	Initial Submission	75%	80%	*Partially Met*
	Resubmission	87%	100%	*Partially Met*

Overall, 87 percent of all applicable evaluation elements received a score of *Met*. Table A-4 presents baseline performance indicator data for **HBN**'s *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table A-4—Performance Indicator Results for HBN's *Satisfaction with Access to Care* (Based on Child CAHPS Survey Responses) PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
The percentage of members for whom a response of "always" or "usually" was provided for Child CAHPS survey Question 23, "In the last 6 months, how often did you get an appointment for your child with a specialist as soon as he or she needed?"	N: 71	84.5%*	N: NA	NA	*Not Assessed*
	D: 84		D: NA		

N–Numerator, D–Denominator
NA–Not Applicable
*HSAG calculated the percentage, 84.5 percent, using the reported numerator and denominator in **HBN**'s PIP submission form. HSAG was unable to replicate **HBN**'s reported percentage of 83.10 percent; therefore, this value was not reported in the table above.

For the baseline measurement period, **HBN** reported that 83.1 percent of members' parents/caregivers who provided a valid response to the Child CAHPS Survey Question 23, "In the last 6 months, how often did you get an appointment for your child with a specialist as soon as he or she needed?" and responded "always" or "usually." Using the baseline numerator and denominator values **HBN** reported in the PIP submission, HSAG calculated a baseline percentage of 84.5 percent.

Interventions

Clinical PIP: *Plan All-Cause Readmissions*

For the *Plan All-Cause Readmissions* PIP, **HBN** used readmissions data, workgroup discussion, intervention evaluation results, drill-down analyses, and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table A-5 displays the barriers and interventions as documented by the health plan for the PIP.

Table A-5—Barriers and Interventions for the *Plan All-Cause Readmissions* PIP

Barriers	Interventions
Poor care transitions	• Targeted high-risk member outreach conducted by **HBN**'s Post Discharge Management program to assist members with appointment scheduling and medication management, and to support compliance with the discharge care plan. • Enrollment of high-risk members into the Care Management program to assist with transition of care (TOC).

Barriers	Interventions
Lack of awareness of resources for addressing social determinants of health (SDOH)	Use of the Find Help platform by **HBN** staff members to assist members in identifying and accessing community and social resources to address needs related to job and income insecurity, transportation, language needs, housing, and food instability.
Inadequate access to care	• Identification of high-volume provider groups that offer telehealth services for members. • LiveHealth Online service for members to address physical and behavioral health needs, and to assist with diagnosis, prescription, and care instructions.
Mental illness	• Member outreach within seven days of an ED visit or inpatient stay discharge, to ensure a follow-up appointment is scheduled and to address any barriers to attending the appointment. • Member educational outreach to all members with an ED visit or inpatient stay discharge on the behavioral health hotline available 24/7 for all members.
Health disparities	List provider ethnicity details in provider directories for members to support informed provider selection.
Lack of support for addressing SDOH	Partnering with a vendor, MedAware, to outreach members at high-risk for readmission to offer a home visit by a local paramedic team and discuss goals and strategies for avoiding readmission such as PCP visits, medication compliance, diet, and exercise.

Nonclinical PIP: *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)*

For the *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)* PIP, **HBN** used readmissions data, workgroup discussion, intervention evaluation results, and drill-down analyses to identify the following barriers and interventions to improve performance indicator outcomes.

Table A-6 displays the barriers and interventions as documented by the health plan for the PIP.

Table A-6—Barriers and Interventions for the *Satisfaction with Access to Care* (Based on Child CAHPS Survey Responses) PIP

Barriers	Interventions
Health disparities	Increase member access to provider ethnicity information to increase access to care by creating a tool that parents/guardians can use to choose the right urgent care provider or specialist for their child.

Barriers	Interventions
Lack of member motivation and satisfaction	Provide monetary and gift card incentives to members for attending prenatal and well-child visits.
Lack of access to specialty care	Expand obstetric and pediatric provider networks to increase access to care for areas with low access to these specialties.
Lack of support for addressing SDOH	**HBN** staff members' use of the Find Help platform to assist members in identifying and accessing community and social resources to address needs related to job and income insecurity, transportation, language needs, housing, and food instability.
	Care Management and vendor, Cotiviti, will perform health risk screeners (HRS) on all members new to the health plan as well as an annual HRS for existing members. The HRS helps the health plan identify existing SDOH barriers and allows the health plan to outreach members to better help them find resources.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **HBN** followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **HBN** reported accurate indicator results and appropriate data analyses and interpretations of results for the *Plan All-Cause Readmissions* PIP. **[Quality]**
- **HBN** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG identified the following opportunity for improvement:

- **HBN** reported indicator results for the *Plan All-Cause Readmissions* PIP that demonstrated a decline in performance from baseline to Remeasurement 2. **[Quality]**
- **HBN** reported inaccurate baseline indicator results for the *Satisfaction with Access to Care (Based on Child CAHPS Survey Responses)* PIP. **[Quality, Timeliness, and Access]**

To address the opportunity for improvement, HSAG offers the following recommendations for **HBN**:

- Ensure quality checks are in place to facilitate accurate reporting of indicator data and quantitative evaluation results for each PIP. Accurate data reporting will provide more meaningful and actionable information to facilitate ongoing improvement. **[Quality]**
- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table A-7 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table A-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Response
Describe initiatives implemented based on recommendations: **HBN** reviews and updates data on a quarterly basis. **HBN** also holds at least one annual PIP workgroup with leaders in all functional areas within the market to review barriers and opportunities for improvement. **HBN** also presents PIP data, barriers and interventions at multiple quarterly quality committees for feedback from internal and external partners.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: No barriers have been identified in reviewing causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement in all committees and workgroups stated above.
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.

Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
Response
Describe initiatives implemented based on recommendations: HBN of Nebraska has utilized multiple QI tools such as fish bone diagrams, process mapping, and failure modes and effects analyses as part of the causal/barrier analyses for PIPs. Some of the usage of these tools have been outlined within each PIP.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: No barriers were identified in implementing and using QI tools for PIPs.
Identify strategy for continued improvement or overcoming identified barriers: HBN will continue utilizing QI tools as part of the causal/barrier analyses.
HSAG Assessment: HBN sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.
Response
Describe initiatives implemented based on recommendations: HBN uses the PDSA cycle to meaningfully evaluate the effectiveness of each intervention on at least a quarterly basis in multiple areas of business including quality committees with both internal and external partners.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: There were no barriers identified in utilizing PDSA cycles to meaningfully evaluate the effectiveness of each intervention.
Identify strategy for continued improvement or overcoming identified barriers: HBN will continue to utilize PDSA cycles on at least a quarterly basis to meaningfully evaluate the effectiveness of each intervention.
HSAG Assessment: HBN sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Measures

Results for Information Systems Standards Review

Table A-8 provides a summary of **HBN**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix E* of this report.

Table A-8—Summary of Compliance With IS Standards for HBN

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed and steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	The LO determined that **HBN** was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that **HBN** only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCEs continually assess data completeness and take steps to improve performance. • The MCEs effectively monitor the quality and accuracy of electronic submissions. • The MCEs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**HBN** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **HBN** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**HBN** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **HBN** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **HBN** reviewed all provider data received from delegated entities.
IS 4.0—MRR Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**HBN** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy.	**HBN** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in nonstandard form that required PSV.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
• Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for ECDS reporting met reporting requirements. • NCQA validated data resulting from the DAV program met reporting requirements.	
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**HBN** was compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by **HBN**'s staff members. Data were verified for accuracy at each data merge point.
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**HBN** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA-certified measure vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **HBN**. According to the DHHS's required data collection methodology, the rates displayed in Table A-10 reflect all final reported rates in **HBN**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **HBN** may have received an "NA" status for an indicator due to a small denominator within the measure but still have received an "R" designation for the total population.

Table A-9—HEDIS Audit Results for HBN

Audit Finding	Description	Audit Result
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	***R***
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	***NA******
The MCO did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	***NB****
The MCO chose not to report the measure.	Not Reported	***NR***
The MCO was not required to report the measure.	Not Required	***NQ****
The rate calculated by the MCO was materially biased.	Biased Rate	***BR***
The MCO chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).	Unaudited	***UN***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table A-10—HBN's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
Effectiveness of Care: Prevention and Screening				
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	67.40%	73.72%	66.91% ★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	68.61%	64.72%	68.13% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	64.48%	61.31%	64.72% ★★	R
CIS: Childhood Immunization Status—Combination 3	70.80%	72.99%	68.37% ★★★	R
CIS: Childhood Immunization Status—Combination 7	—	64.72%	60.83% ★★★★	R
CIS: Childhood Immunization Status—Combination 10	47.69%	54.26%	43.80% ★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, toxoids and acellular pertussis [Tdap])	75.18%	77.13%	81.51% ★★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	—	31.14%	29.44% ★★	R
LSC: Lead Screening in Children	72.26%	70.80%	69.10% ★★★	R
BCS: Breast Cancer Screening	40.62%	42.69%	44.95% ★	R
CCS: Cervical Cancer Screening	63.99%	58.88%	57.11% ★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20	29.24%	26.60%	29.27% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24	40.39%	37.70%	40.85% ★	R
CHL: Chlamydia Screening in Women—Total	32.97%	30.90%	34.00% ★	R
Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	73.83%	74.12%	71.96% ★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	63.57%	65.29%	64.10% ★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65+	NA	NA	NA	R
CWP: Appropriate Testing for Pharyngitis—Total	72.20%	71.81%	69.55% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	20.30%	28.00%	15.71% ★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	34.02%	56.29%	54.90% ★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	43.44%	71.86%	64.71% ★	R
AMR: Asthma Medication Ratio—Ages 5 to 11	72.64%	75.36%	80.00% ★★★	R
AMR: Asthma Medication Ratio—Ages 12 to 18	58.84%	62.07%	66.77% ★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	55.49%	60.92%	67.69% ★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	59.46%	61.36%	73.50% ★★★★	R
AMR: Asthma Medication Ratio—Total	63.42%	66.04%	71.23% ★★★★	R
Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure	52.80%	53.04%	69.10% ★★★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	65.91%	79.49% ★★	R
Effectiveness of Care: Diabetes				
HBD: Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Control (<8.0%)	45.01%	48.66%	47.69% ★★	R
*HBD: HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)**	45.74%	40.88%	41.61% ★★	R
BPD: Blood Pressure Control for Patients With Diabetes	63.02%	66.18%	71.05% ★★★★	R
EED: Eye Exam for Patients With Diabetes	52.07%	50.61%	52.55% ★★★	R
Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.99%	61.69%	56.05% ★★	R
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	40.25%	47.66%	41.84% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	44.11%	38.99%	44.62% ★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	56.72%	46.78%	53.01% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	55.00%	44.95%	53.20% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	75.00%	70.41%	73.73% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	34.57%	34.25%	33.81% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	54.26%	53.59%	52.69% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	42.19%	37.60%	39.58% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.17%	58.86%	58.97% ★★★	R
FUM: Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total	41.79%	40.91%	38.43% ★★	R
FUM: Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	61.59%	59.25%	56.60% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)—7-Day Follow-Up—Total	27.43%	23.24%	24.53% ★★	R
FUI: Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	42.29%	43.37%	42.18% ★★	R
FUA: Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total	—	—	24.34% NC	R
FUA: Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	—	—	38.01% NC	R
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.25%	76.78%	79.52% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	53.19%	48.86%	58.73% ★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.61%	52.89%	50.58% ★	R
Effectiveness of Care: Overuse/Appropriateness				
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.31%	0.20%	0.21% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	88.71%	90.20%	90.77% ★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64	77.84%	80.47%	83.23% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65+	94.32%	NA	NA	R
URI: Appropriate Treatment for Upper Respiratory Infection—Total	87.51%	88.75%	89.38% ★★	R
LBP: Use of Imaging Studies for Low Back Pain—Total	—	—	74.53% NC	R
*HDO: Use of Opioids at High Dosage**	4.75%	2.06%	2.06% ★★★	R
Access/Availability of Care				
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 13 to 17	—	—	28.22% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 13 to 17	—	—	12.33% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 18 to 64	—	—	35.99% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 18 to 64	—	—	10.85% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 65+	—	—	25.37% NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 65+	—	—	7.46% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total	—	—	34.88% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total	—	—	10.95% NC	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.32%	76.16%	79.56% ★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	77.13%	68.37%	78.59% ★★★	R
Utilization[2]				
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.95%	60.83%	63.05% ★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	72.67%	66.85%	67.63% ★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total^**	435.48	532.56	568.00 ★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^*	3,517.2	3,891.36	3,928.06 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total^*	93.84	69	67.10 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total	4.60	7.32	5.50 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total^*	66.24	45.36	39.30 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total	2.41	2.45	2.56 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total^*	15.36	12.36	15.10 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total	9.00	9.15	10.98 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total^*	43.92	28.8	26.63 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total	4.77	11.25	5.20 NC	R
Risk Adjusted Utilization				
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	10.51%	11.33%	12.41% NC	R
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.27%	10.40%	10.55% NC	R
*PCR: Plan All-Cause Readmissions—Observed to Expected (O/E) Ratio—Total**	0.93	1.09	1.18 ★	R
Measures Collected Using Electronic Clinical Data Systems				
BCS-E: Breast Cancer Screening	—	—	—	NR

[1] Due to changes in percentile rankings represented in star ratings between MY 2021 and MY 2022, star ratings are displayed for MY 2022 only.
[2] In the Utilization domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for informational purposes only.
* For this indicator, a lower rate indicates better performance.
^ For this indicator, the rate is reported per 1,000 member months rather than a percentage.
NA indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2022 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table A-11—HBN's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
Adult Core Measures			
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	—	32.85%	32.48%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 18 to 64**	—	3.09%	1.98%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+**	—	3.45%	5.00%
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 18 to 64[1]	—	—	—
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 65+[1]	—	—	—
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 18 to 64 Years**	—	17.58%	18.27%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 65 Years and Older**	—	22.22%	10.53%
Child Core Measures			
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 1 Year	—	21.02%	33.58%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 2 Years	—	30.45%	37.23%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 3 Years	—	26.61%	31.39%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	26.13%	34.06%
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17[1]	—	—	—
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Most or moderately effective contraception (MMEC)—within 3 days of delivery	—	—	1.53%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—MMEC—within 90 days of delivery	—	—	35.88%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20 Long-acting reversible method of contraception (LARC)—within 3 days of delivery	—	—	0.00%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—LARC—within 90 days of delivery	—	—	18.32%

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—MMEC	—	—	26.07%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—LARC	—	—	4.30%

[1] The CMS Adult and Child Core Set measures *CDF-AD* and *CDF-CH* were purposely excluded from the template DHHS supplied to the MCO for Core Measures reporting. The MCO did not report on these measures for the MY 2022 period.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year(s).

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*; *Immunizations for Adolescents—Combination 1*; *Lead Screening in Children*; and *Cervical Cancer Screening* measure indicators were a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. The *Immunizations for Adolescents—Combination 1* rate demonstrates that adolescents were receiving immunizations to help protect them against meningococcal disease and tetanus, diphtheria, and pertussis. The *Lead Screening in Children* rate demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they maintained limited exposure to lead. Lastly, the *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 were receiving screening for one of the most common causes of cancer death in the United States. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 5 to 11, Ages 19 to 50, Ages 51 to 64,* and *Total* measure indicators were a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The rates for these measure indicators demonstrate that **HBN** providers effectively managed this treatable condition for members with persistent asthma. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for the measure. The rate for this measure demonstrates that **HBN** providers helped members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality and Timeliness]**

Effectiveness of Care: Diabetes Domain

The *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)* and *Eye Exam for Patients With Diabetes* measures were a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for both measures. The *Blood Pressure Control for Patients With Diabetes* rate demonstrates that **HBN** providers helped adult members with diabetes adequately control their blood pressure. Additionally, the *Eye Exam for Patients With Diabetes* rate demonstrates that **HBN** providers ensured that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

For the following measure indicators, **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark:

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase* **[Quality, Timeliness, and Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total) and 30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total)* **[Quality, Timeliness, and Access]**
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**

The *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* rates demonstrate that **HBN** providers ensured that children prescribed ADHD medication participated in timely initial and continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that **HBN** providers ensured that members hospitalized for mental illness received adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* rate demonstrates that **HBN** providers effectively managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rate demonstrates that **HBN** providers effectively ensured that adult members on antipsychotics were screened for diabetes, resulting in positive health outcomes for this population. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Non-Recommended Cervical Cancer Screening in Adolescent Females*, *Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64*, and *Use of Opioids at High Dosage* measure indicators were a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate demonstrates that **HBN** providers ensured that members did not receive unnecessary cancer screenings. The *Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64* rate demonstrates that, for adult members, **HBN** providers effectively managed the dispensing of antibiotic medication to treat URI. Lastly, the *Use of Opioids at High Dosage* rate demonstrates that **HBN** providers prevented or minimized the prescribing of opioids at a dosage of ≥ 90 mg morphine equivalent dose. **[Quality]**

Access/Availability of Care Domain

The *Prenatal and Postpartum Care—Postpartum Care* measure indicator was a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The rate for this measure indicator demonstrates that **HBN** providers ensured that members received timely and adequate postpartum care, in alignment with guidance provided by the AAP and the ACOG. **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators were a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates demonstrate that **HBN** providers ensured that children were seen by a PCP within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**

The *Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total* measure indicator was also a strength for **HBN**. **HBN** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The *Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total* rate demonstrates that **HBN** providers ensured members received appropriate primary care to reduce preventable visits to the ED.

Risk Adjusted Utilization

HSAG did not identify any strengths when conducting the PMV for **HBN** within the *Risk Adjusted Utilization* domain.

Measures Collected Using Electronic Clinical Data Systems

HSAG did not identify any strengths when conducting the PMV for **HBN** within the *Measures Collected Using ECDS* domain.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*; *Breast Cancer Screening*; and *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were a weakness for **HBN**. **HBN** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. HSAG recommends that **HBN** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. HSAG also recommends that **HBN** conduct a root cause analysis to determine whether female members are not receiving preventive screenings for breast cancer. Lastly, HSAG recommends that **HBN** providers follow up annually with sexually active members through various modes of communication to ensure members return for yearly screening. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17*, *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators were a weakness for **HBN**. **HBN** ranked below the NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. The *Appropriate Testing for Pharyngitis—Ages 3 to 17* rate suggests that child and adolescent members did not receive proper testing to merit antibiotic treatment for pharyngitis. HSAG recommends that **HBN** work with providers to determine whether children and adolescents are properly tested to prevent the unnecessary use of antibiotics. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* rate suggests that **HBN** providers are not conducting spirometry testing to diagnose COPD, as recommended by the Global Initiative for Chronic Obstructive Lung Disease. [A-1] HSAG recommends that **HBN** conduct a root cause analysis to identify the factors that contributed to the substantial decrease in the rate for this measure from MY 2021 to MY 2022. The *Pharmacotherapy Management of COPD Exacerbation* rate suggests that members did not have appropriate medication to manage COPD exacerbations. HSAG recommends that **HBN** work with its pharmacy data to identify opportunities to refill prescriptions in a timely manner and to assist members

[A-1] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease."

with barriers to refilling prescriptions (e.g., members needing transportation to the pharmacy or possible billing challenges at the point of sale). **[Quality, Timeliness, and Access]**

Effectiveness of Care: Cardiovascular Conditions Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the *Effectiveness of Care: Cardiovascular Conditions* domain.

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the *Effectiveness of Care: Diabetes* domain.

Effectiveness of Care: Behavioral Health Domain

The *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure indicators were weaknesses for **HBN**. **HBN** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. The *Diabetes Monitoring for People With Diabetes and Schizophrenia* rate suggests that **HBN** providers were not properly monitoring the status of members with diabetes who used antipsychotics. Additionally, the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rate suggests that members with schizophrenia or schizoaffective disorder did not receive adequate support to ensure adherence to their treatment plan and antipsychotic medications. HSAG recommends that **HBN** review its data production process for these measures to ensure no claims are missing and all available data are being collected for the measures. **HBN** might also consider performance-based incentives for its behavioral health provider network to ensure that all providers are adequately monitoring and supporting high-risk members. **[Quality and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **HBN**. **HBN** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark on this measure indicator. The rate for this measure indicator suggests that a diagnosis of URI resulted in an antibiotic dispensing event for child and adolescent members. HSAG recommends that **HBN** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG continues to recommend that **HBN** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator was a weakness for **HBN**. **HBN** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. The rate for this measure indicator suggests that

members did not receive timely and adequate prenatal care. HSAG recommends that **HBN** work with its providers on best practices for providing ongoing prenatal care. **[Quality, Timeliness, and Access]**

Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the *Utilization* domain.

Risk Adjusted Utilization

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **HBN**. **HBN** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. HSAG recommends that **HBN** work with its providers to ensure diagnosis and treatment of members are complete and precise to improve readmission rates. **[Quality]**

Measures Collected Using Electronic Clinical Data Systems

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the *Measures Collected Using ECDS* domain.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table A-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table A-12—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for Prevention and Screening Domain
• The *Breast Cancer Screening* measure was a weakness for **HBN**. For this measure, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. This rate indicates women were not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment and higher health care costs. HSAG continued to recommend that **HBN** conduct a root cause analysis or focus study to determine why its female members are not receiving preventive screenings for breast cancer. DHHS and **HBN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **HBN** should implement appropriate interventions to improve performance. If the rate in women receiving these services is identified to be related to the continuation of the Coronavirus Disease 2019 Public Health Emergency (COVID-19 PHE), DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services. • The *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were also a weakness for **HBN**. For these measure indicators, **HBN**'s rates ranked below NCQA's Quality Compass

national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic. HSAG continued to recommend that **HBN** providers follow up annually with sexually active members through any type of communications such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuation of the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for ensuring ongoing access to these important services.

Response

Describe initiatives implemented based on recommendations: Breast Cancer Screening:
HBN of Nebraska continued to offer a $50 Healthy Reward incentive throughout 2022 for members who received breast cancer screenings. After further evaluation and root cause analysis **HBN** also implemented member call and texting campaigns to remind members of the importance of breast cancer screenings and encouragement to receive appropriate screening. **HBN** also began conversations with Advanced Medical Imaging and Blue Cross Blue shield to purchase a mobile mammogram unit, this initiative is currently on hold due to RFP.
Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24, and Total measure: Total 21:
HBN of Nebraska implemented member texting campaign and an internal gap in care contest where care management helps educate and encourage screening for measure with all appropriate members, they interact with in 2022.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Breast Cancer Screening:
2021: 42.69%
2022: 44.95%
YOY: +2.26

Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24, and Total measure:
Ages 16 to 20
2021: 26.60%
2022: 29.27%
YOY: +2.67

Ages 21 to 24
2021: 37.70%
2022: 40.85%
YOY: +3.15

Total
2021: 30.90%
2021: 34.00%
YOY: +3.10

Identify any barriers to implementing initiatives: Breast Cancer Screening: **HBN** identified barriers after analysis of measure and interventions including wrong member phone numbers and addresses, timing of COVID 19 vaccination and mammogram required by CMS and lack of understanding of importance of screening in healthy woman.

Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24, and Total measure: **HBN** identified barriers after analysis of measure and interventions including wrong member phone numbers and addresses and lack of understanding of importance of screening in healthy woman.
Identify strategy for continued improvement or overcoming identified barriers: Breast Cancer Screening: **HBN** of Nebraska will continue all member call and texting campaigns as well as the $50 healthy reward incentive. In 2023 **HBN** has begun working closely with large providers to ensure members are encouraged from both the health plan and their provider to receive their breast cancer screening. Chlamydia Screening in Women—Ages 16 to 20, Ages 21 to 24, and Total measure: In 2023 **HBN** has begun working with Nebraska's health information exchange for better data capture. **HBN** will continue to educate members of the importance of chlamydia screening in women.
HSAG Assessment: **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Breast Cancer Screening* measure. **HBN**'s performance on the *Breast Cancer Screening* measure improved from MY 2021 to MY 2022 because of the efforts **HBN** undertook to encourage screenings for breast cancer. However, **HBN**'s MY 2022 rate on this measure remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s use of incentives and outreach campaigns to encourage adult women members to receive a breast cancer screening and recommends that **HBN** continue these efforts. HSAG also recognizes **HBN**'s work to secure mobile mammogram units to enhance members' access to breast cancer screening and recommends that **HBN** resume this initiative, if possible. **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Chlamydia Screening in Women* measure indicators. **HBN**'s performance on the *Chlamydia Screening in Women* measure indicators improved from MY 2021 to MY 2022 because of the efforts **HBN** undertook to educate and encourage screening for women members who were sexually active. However, **HBN**'s MY 2022 rates on these measure indicators remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s use of outreach campaigns to educate women members about the importance of chlamydia screening and recommends that **HBN** continue these efforts. HSAG also commends **HBN**'s use of data from Nebraska's health information exchange to better identify care gaps that impact performance on these measure indicators.
Recommendations for Respiratory Conditions Domain
The *Asthma Medication Ratio—Ages 12 to 18* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators were a weakness for **HBN**. For these measure indicators, **HBN**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. These rates indicate that **HBN** providers are not handling asthma appropriately as a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs for all stakeholders involved. HSAG continued to recommend that **HBN** conduct a root cause analysis to determine if the rate of the *Asthma Medication Ratio* measure is being affected due to an access to care or management of member medication issue. In addition, based on the rates, **HBN** providers are not appropriately prescribing medication to prevent and help members control their COPD related to the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. HSAG continued to recommend that **HBN** work with its pharmacy data to identify opportunities to refill prescriptions in a timelier manner and to assist members with barriers to refilling prescriptions (e.g., members needing transportation to the pharmacy or possible billing challenges at the point of sale).

Response
Describe initiatives implemented based on recommendations: The Asthma Medication Ratio—Ages 12 to 18 (AMR) **HBN** is engaged in focused efforts to educate asthmatic members. An educational article was published in our Member Newsletter promoting tips for Asthma Management in the Summer of 2022. We offer a value- added benefit for members to receive up to $200.00 worth of asthma relief products which is listed in our Member Handbook. Additionally, we offer a Condition Care program for members with Asthma. Our registered nurses help members manage the condition, or health issues that may improve quality of life. **HBN** extends a $20.00 reimbursement to providers for documenting the CPT II code for assessing asthma impairment. **HBN** offers many outreach programs via our Pharmacy vendor CarelonRx to both members and providers: o Monthly Prescriber faxes addressing extended day supply and asthma medication adherence. o Daily calls to members focusing on new member education, late refills, and asthma medication adherence. Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator: (PCE) **HBN** offers a Condition Care program for members with COPD. Our registered nurses help member manage the condition, or health issues that may improve quality of life. In addition, CarelonRx conducts a COPD Post Discharge outreach program that sends a fax and call to the prescriber that is identified daily.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Asthma Medication Ratio—Ages 12 to 18 **HBN** noted an improvement of 4.7% percentage points from 2021 to 2022 rates. Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator None
Identify any barriers to implementing initiatives: The Asthma Medication Ratio—Ages 12 to 18 None Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator This measure is time sensitive (within 30 days for bronchodilator and 14 for systemic corticosteroid) based on acute inpatient discharges and ED visits making it difficult to proactively capture and pursue members within this threshold.
Identify strategy for continued improvement or overcoming identified barriers: The Asthma The Asthma Medication Ratio—Ages 12 to 18 **HBN** has ongoing provider education of the benefits of submitting CPTII codes and the profits of establishing a flat file feed for ongoing result submission for gap closure. Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator **HBN** has ongoing provider education on suggested coding to close gap. In addition to quarterly submission and review of gap in care report to educate on best practices and opportunities for closure. **HBN** continues to monitor and identify opportunities for improvement.
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations regarding the *Asthma Medication Ratio—Ages 12 to 18* measure indicator. **HBN**'s performance on the *Asthma Medication Ratio—Ages 12 to 18* measure

indicator improved from MY 2021 to MY 2022 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

HBN did not sufficiently address the CY 2022–2023 recommendations regarding the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators. **HBN**'s performance on the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators declined from MY 2021 to MY 2022 and remains below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s efforts to ensure members with COPD received treatment to manage their symptoms and prevent exacerbations and recommends that **HBN** continue these efforts. HSAG also commends **HBN**'s work with providers to implement best practices for COPD management and to close care gaps.

Recommendations for Cardiovascular Conditions Domain

- The *Controlling High Blood Pressure* and *Persistence of Beta-Blocker Treatment After a Heart Attack* measures were weaknesses for **HBN**. For these measures, **HBN**'s rates ranked at or below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. The *Controlling High Blood Pressure* measure rate indicates that **HBN** providers are not handling the monitoring and controlling of members' blood pressure appropriately in helping to prevent heart attacks, stroke, and kidney disease. Providers can help manage members' blood pressure through medication, encouraging low-sodium diets, increased physical activity, and smoking cessation. HSAG recommended **HBN** conduct a root cause analysis to ensure providers are working with members who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) and identify any areas of evaluation that might be missed by the providers during member visits.
- In addition, the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure rate indicates adults 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction were not appropriately receiving persistent beta-blocker treatment for six months after discharge. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. Beta-blockers work by lowering the heart rate. This reduces the amount of force on the heart and blood vessels. HSAG recommended **HBN** conduct a root cause analysis as to ensure providers are working with members who were discharged with a diagnosis of acute myocardial infarction and identify any areas of evaluation that might be missed by the providers during member visits to ensure treatment is being addressed and issued appropriately.

Response

Describe initiatives implemented based on recommendations:

Controlling Blood pressure: (CBP)

HBN has included this measure, CBP, as an option for provider value-based contracts that is a HEDIS Hybrid measure that provides a deep medical record dive for capturing blood pressure results. **HBN** received full state withhold for MY 2022. We deliver Provider Education of submitting CPTII coding and the benefits of establishing a flat file feed for ongoing result submission for gap closure. This measures also offers a Provider P4Q $30 incentive for providers not otherwise involved in an VBC incentive program. Members may receive a Healthy Reward of $10 per prescription up to $40; that will continue through next year 2023.

Healthy Blue's Pharmacy vendor, CarelonRx has a couple of medication adherence programs for both member and provider reminders. In addition, Care and Utilization Management have programs to assist and educate members on the treatment and management of Hypertension.

Persistence of Beta Blocker Treatment after a heart attack (PBH)

- Quarterly, **HBN** of Nebraska monitors HTN by race focusing on ER visits and inpatient stays (root cause analysis). From a Whole Health perspective, **HBN** analyzed hypertension data by race to determine where the greatest opportunities for improvement lie. Hospital inpatient days and ER visits were measured for AA, AI, and Hispanic individuals with hypertension. Compared to a 2022 baseline, Q2 2023 rates show a positive decline for all groups except AI. The AI group rates were steady and it is expected that they will also see a downward trend once all claims are processed. The strong focus on person centered outreach by multiple **HBN** functional areas appears impactful and will continue for 2023.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Controlling Blood pressure: (CBP)
HBN noted an improvement of 16.06% percentage points from 2021 to 2022 rates.

Persistence of Beta Blocker Treatment after a heart attack (PBH)
HBN noted an improvement of 13.58% percentage points from 2021 to 2022 rates.

Identify any barriers to implementing initiatives:

Controlling Blood pressure: (CBP)
None

Persistence of Beta Blocker Treatment after a heart attack (PBH)
None

Identify strategy for continued improvement or overcoming identified barriers: Controlling Blood pressure: (CBP) and Persistence of Beta Blocker Treatment after a heart attack (PBH)
In March and April of 2023, we held a class at the Malone Center by UNL extension focusing on Black members with HTN, education on diet and medication adherence.
HBN holds ongoing Health Fairs providing Hypertension and Blood Pressure education and sponsorships focused on food deserts areas. From a Case Management perspective, member may be pulled to CM queues such as post discharge management (PDM) or emerging risk management (ERM).
HBN of Nebraska also has ongoing provider education of submitting CPTII coding and the benefits of establishing a flat file feed to receive monthly data feeds from providers for data not captured via claims.
HBN continues quarterly monitoring of hypertension diagnosis for stratified population by race.
OB providers are given education & support to identify & treat gestational HTN for members of color. The Plan distributed Telehealth kits to members with hypertension diagnosis in 2022; with continued efforts well into 2023.

HSAG Assessment:

HBN sufficiently addressed the CY 2022–2023 recommendations regarding the *Controlling High Blood Pressure* measure. **HBN**'s performance on the *Controlling High Blood Pressure* measure improved from MY 2021 to MY 2022 and is now at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark.

HBN sufficiently addressed the CY 2022–2023 recommendations regarding the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure. **HBN**'s performance on the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure improved from MY 2021 to MY 2022 and is now above the NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

Recommendations for Behavioral Health Domain
The *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measures were a weakness for **HBN**. For these measures, **HBN**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Because members with serious mental illness (SMI) who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. HSAG continued to recommend that **HBN** review its data production process for this measure to ensure no claims are missing and all available data are being collected for the measure. **HBN** might also consider performance-based incentives for its behavioral health provider network to ensure that all providers are prioritizing physical health screenings for high-risk members.
Response
Describe initiatives implemented based on recommendations: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): **HBN** implemented provider and member education in 2022 to help improve the SAA measure. **HBN** also began working on getting a member texting campaign established. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD): **HBN** continues to offer a $25 healthy reward for members who have their labs drawn. **HBN** also calls members on a market level and reminds them to get in for screening and helps schedule appointment.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): N/A Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD): 2021: 48.86% 2022: 58.73% YOY: +9.87
Identify any barriers to implementing initiatives: SAA and SMD: **Healthy Blue**'s biggest barrier for the SAA measure was working phone numbers and addresses for members.
Identify strategy for continued improvement or overcoming identified barriers: SAA and SMD: **HBN** will continue to educate members and providers on the importance of Diabetes Monitoring for People with Diabetes and Schizophrenia and Adherence to Antipsychotic Medications for Individuals with Schizophrenia.
HSAG Assessment: **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure. **HBN**'s performance on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure improved from MY 2021 to MY 2022. However, **HBN**'s MY 2022 rate on this measure remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s use of incentives and outreach campaigns to encourage members with schizophrenia or schizoaffective disorder to receive diabetes screening and recommends that **HBN** continue these efforts. **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure. **HBN**'s performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure declined from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile

benchmark. HSAG recognizes **HBN**'s work with providers and members with schizophrenia or schizoaffective disorder to improve adherence to antipsychotic medication and recommends that **HBN** continue this work.

Recommendations for Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG continued to recommend that **HBN** conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria. In addition, HSAG continued to recommend that providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.

Response

Describe initiatives implemented based on recommendations: **Healthy Blue**'s Pharmacy vendor, CarelonRx has a medication review and note program of provider faxes including the following messages that began in Jan 2023 for:

1) Acute Bronchitis antibiotic Rx: Identifying patients through claims that filled and antibiotic after being diagnosed with acute bronchitis and acknowledging it may be appropriate in some cases of bronchitis, but the CDC encourage a conservative approach due to concerns about safety and antibiotic resistance.
2) Upper Respiratory infection Antibiotic Rx: : Identifying patients through claims that filled and antibiotic after being diagnosed with an URI and acknowledging it may be appropriate in some cases of URI, but the CDC encourage a conservative approach due to concerns about safety and antibiotic resistance.

HBN distributed Quality Toolkits in 2022 and 2023 to include HEDIS coding book and many quality tools to assist providers with closing gaps in care.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): None

Identify any barriers to implementing initiatives: Properly educating members on the difference between viral and bacterial infections and appropriate treatment.

Identify strategy for continued improvement or overcoming identified barriers: **HBN** Quality Management developed a strategy for improving provider support with a focus on onsite/virtual visits (began 2023), providing assistance with EMR workflow(s) and education.
HBN will continue to educate members and providers on the importance of appropriate treatment.

HSAG Assessment:

HBN did not sufficiently address the CY 2022–2023 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator. **HBN**'s performance on the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was consistent from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s work with its pharmacy vendor and providers to ensure the appropriate prescribing of antibiotics and to close care gaps, and recommends that **HBN** continue these efforts.

Recommendations for Access/Availability of Care Domain

- The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17* measure indicator was a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021

25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care. HSAG recommended that **HBN** work with its providers to ensure they are reaching members with identified SUD and to engage in follow-up treatment. **HBN** might consider working with providers to illustrate the time sensitivity of the measure requirements and ask providers about their strategies for engagement in treatment.

- The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were also a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Studies indicate that as many as 60 percent of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care, and made changes in their health and lifestyle habits. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. HSAG recommended that **HBN** work with its providers on best practices for providing ongoing prenatal care. This is especially important during the continuation of the COVID-19 PHE, as pregnant and recently pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women.

Response

Describe initiatives implemented based on recommendations: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17: In 2022 **HBN** began working closely with providers educating them on the importance of this measure. **HBN** also added a $5 healthy reward for parents to take a substance use quiz for educational purposes. Care management continues to work closely with high-risk members and their parents or guardians on receiving proper help for a substance use diagnosis. **HBN** also began working with behavioral health providers to encourage use of telehealth kiosks for members to see a behavioral health substance use provider in a timely manner through **Healthy Blue**'s telehealth vendor Live Health Online.

The Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care: In 2022 **HBN** worked closely with OBQIP providers on ensuring members are getting in for their prenatal appointments and postpartum appointment within recommended timeframe. **HBN** also implemented a provider incentive for notifying the health plan of a new member pregnancy within first 12 weeks. **HBN** continued to offer $25 prenatal and $25 postpartum healthy reward and multiple value-added benefits for pregnant members, in 2022 the health plan worked hard on marketing these incentives to ensure members were educated on opportunities.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17:
N/A

The Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care:

Prenatal:
2021: 76.16%
2022: 79.50%
YOY: +3.34

Postpartum:
2021: 68.37%

2022: 78.50% YOY: +10.13
Identify any barriers to implementing initiatives: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17: Timely notification of substance use diagnosis continues to be a barrier for **HBN** and the IET measure. Without timely notification of the new substance use diagnosis, it is difficult to contact provider and member to get proper appointment within recommended timeframe for measure. Lack of substance use providers within the state especially in rural Nebraska continues to be a barrier as well as wrong member contact information. The Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care: Bundled billing continues to be a barrier for **HBN** to correctly capture all prenatal and postpartum appointments. Incorrect member contact information and the 90 look back period for newly enrolled Medicaid members have also been barriers for the health plan getting members in for proper OB care within time frames outlined in both measures.
Identify strategy for continued improvement or overcoming identified barriers: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17: **HBN** will continue to educate providers and members on importance of substance use behavioral health appointment after a substance use diagnosis as well as continue to encourage telehealth appointments for better access to care. **HBN** will also conduct medical record reviews and provider coding education for better data capture for measure. The Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care: **HBN** will continue to educate providers and members on importance of prenatal and postpartum care within the recommended timeframes. The health plan will continue to offer healthy reward and value-added benefits for members. In 2023 **HBN** also began year round record reviews for OB members for improved data capture.
HSAG Assessment: The technical specifications for the *Initiation and Engagement of SUD Treatment* measure underwent major changes in MY 2022. Therefore, MY 2022 results for this measure are not comparable to MY 2021 results. **HBN** sufficiently addressed the CY 2022–2023 recommendations regarding the *Prenatal and Postpartum Care—Postpartum Care* measure indicator. **HBN**'s performance on the *Prenatal and Postpartum Care—Postpartum Care* measure indicator improved from MY 2021 to MY 2022 and is now at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark. **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. **HBN**'s performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator improved from MY 2021 to MY 2022. However, **HBN**'s MY 2022 rate on this measure indicator remains below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s efforts involving providers and members to ensure the delivery of prenatal care within the recommended time frame and recommends that **HBN** continue these efforts.
Recommendations for Risk Adjusted Utilization Domain
The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. A "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs.

Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management. HSAG recommended that **HBN** work with its providers to ensure diagnosis and treatment of members are complete and precise in order to improve readmission rates.
Response
Describe initiatives implemented based on recommendations: In 2022 **HBN** of Nebraska began encouraging Vivitrol for members with an alcoholism diagnosis to help decrease physical and behavioral health diagnosis. The health plan also continued to outreach to high risk members through our care management department to offer addition assistance related to health and SDOH concerns. **HBN** also started breaking data down into ethnicities, age and gender to better analyze PCR data to implement interventions. Due to this analysis **HBN** also added a provider ethnicity section on the health plan's provider look up tool on the plan's member website to help members find a provider who is able to meet all of their needs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: Behavioral health readmissions continue to be a barrier for **HBN** as well as correct member contact information.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to outreach members who are high risk for behavioral health and physical health on a market level. **HBN** will continue to promote the Vivitrol injection for members with an alcoholism diagnosis. **HBN** will continue to analyze interventions and data on a quarterly basis and present findings at workgroups and committees.
HSAG Assessment: **HBN** did not sufficiently address the CY 2022–2023 recommendations regarding the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator. **HBN**'s performance on the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator declined from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **HBN**'s efforts to identify and address causes of readmissions and recommends that **HBN** continue these efforts.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table A-13—Compliance With Regulations—Trended Performance for HBN

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**	Year Three (2023–2024)**
Standard Number and Title	**HBN Results**		
Standard I—Enrollment and Disenrollment	100%	100%	
Standard II—Member Rights and Confidentiality	83%		100%
Standard III—Member Information	77%		90.9%
Standard IV—Emergency and Poststabilization Services	100%	100%	
Standard V—Adequate Capacity and Availability of Services	86%		100%
Standard VI—Coordination and Continuity of Care	100%		100%
Standard VII—Coverage and Authorization of Services	84%		94.7%
Standard VIII—Provider Selection and Program Integrity	94%	94%	
Standard IX—Subcontractual Relationships and Delegation	100%	75%	
Standard X—Practice Guidelines	100%	100%	
Standard XI—Health Information Systems	100%	100%	
Standard XII—Quality Assessment and Performance Improvement	100%	100%	
Standard XIII—Grievance and Appeal System	77%		100%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Strengths

HBN submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Four out of six standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

HBN achieved full compliance in the Member Rights and Confidentiality standard, indicating members are receiving timely and adequate access to information that can assist them in accessing care and services. **[Access]**

HBN achieved full compliance in the Adequate Capacity and Availability of Services standard, demonstrating the MCE maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**

HBN achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for its care management program. **[Quality, Timeliness, and Access]**

HBN achieved full compliance in the Grievance and Appeal System standard, demonstrating the MCE had processes in place for handling member complaints, grievances, and appeals. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

HBN should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

HBN received a score of 90.9 percent for the Member Information standard. On HBN's website and in any other electronic member-facing documents, the MCE must include a statement informing the member that the information available electronically is also available in paper form without charge upon request and is to be *provided within five business days.* Additionally, HBN's member handbook did not include the requirement, "the availability of assistance to request a State fair hearing." The MCE must include this requirement in its member handbook. **[Access]**

HBN received a score of 94.7 percent for the Coverage and Authorization of Services standard. HSAG recommended that HBN review all applicable documents to remove the reference to three calendar days, as the expedited timeline is set by the federal regulations as 72 hours. Furthermore, HBN must include provisions to inform members of the right to file a grievance if they disagree with the decision for the MCE to extend the time frame for making standard or expedited authorization decisions. **[Timeliness and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table A-14 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table A-14—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendations
HBN should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.
Response
Describe initiatives implemented based on recommendations: HBN Compliance department reviewed the findings and recommendations. Action items will include updating member and provider material, and policies to follow the recommendations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HBN continues to monitor.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: HBN Compliance team will collaborate with all departments to monitor improvements of recommendations; engage in a rapid response change process, if needed to improve outcomes further.
HSAG Assessment: HBN sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
HBN received a score of 94 percent for the Provider Selection and Program Integrity standard and 99 percent on the recredentialing record reviews. During the sample record review, HSAG determined that one file exceeded the recredentialing time period of 36 months. **HBN** must follow its documented process for recredentialing within 36 months, which complies with the requirements of the contract.
Response
Describe initiatives implemented based on recommendations: The file that exceeded 36 months was human error. We have a recredentialing report that tracks files currently in process. All staff were trained in reviewing the recredentialing report. We also had a refresher training in the requirements to process or close a recredentialing file within 36 months.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As a result of this training recredentialing files have been processed within their 36 month required timeframe. In the presentation to HSAG, we provided compliance reports and process flow documents demonstrating our compliance.
Identify any barriers to implementing initiatives: No.
Identify strategy for continued improvement or overcoming identified barriers: Continue trainings and monitoring of files.
HSAG Assessment: HBN sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
HBN received a score of 75 percent for the Subcontractual Relationships and Delegation standard. Upon HSAG's review, **HBN**'s delegation agreement with their pharmacy benefit manager (PBM), did not include all provisions required by federal regulations and **HBN**'s contract with DHHS.

Response
Describe initiatives implemented based on recommendations: All provisions required by federal regulations and **HBN**'s contract with DHHS have been added to the **HBN**'s delegation agreement with CVS the pharmacy benefit manager.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: No barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: N/A
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
HBN must ensure that all contracts and written agreements specify the following provisions: • The State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
Response
Describe initiatives implemented based on recommendations: All provisions required by federal regulations and **HBN**'s contract with DHHS have been added to the **HBN**'s delegation agreement with CVS the pharmacy benefit manager.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: No barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: N/A
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Network Adequacy

Results

Network Capacity Analysis

The number of members enrolled with **HBN** was determined from the Medicaid enrollment data provided by DHHS. Table A-15 provides the number of eligible members in each population used to measure the adequacy of **HBN**'s provider network. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYNs were limited to female members 15 years of age and older.

Table A-15—Population of Eligible Members for HBN by Urbanicity

Member Population	Members
Children 18 Years and Younger	68,310
Females 15 Years and Older	44,449
All Members*	130,937

*"All Members" may not equal the sum of "Children 18 Years and Younger" and "Females 15 Years and Older" as the latter categories overlap and do not include adult males. In addition, "All Members" includes members whose age was not known.

Table A-16 displays **HBN**'s statewide network capacity analysis results (i.e., the number of providers and provider ratios) for all applicable provider categories alongside results for pediatric specialists in appropriate provider categories. Pediatric providers were identified by a combination of taxonomy codes and provider specialties in the MCO provider data.

Table A-16—Network Capacity Analysis Results for HBN by Provider Category*

Provider Category	Providers	Ratio**
PCPs	4,320	1:31
PCPs, Pediatric	3,037	1:23
High-Volume Specialists* **		
Cardiologists	250	1:524
Cardiologists, Pediatric	26	1:2,628
Neurologists	210	1:624
Neurologists, Pediatric	16	1:4,270
OB/GYNs	355	1:126

Provider Category	Providers	Ratio**
Oncologists/Hematologists	114	1:1,149
Oncologists/Hematologists, Pediatric	13	1:5,255
Orthopedics	283	1:463
Orthopedics, Pediatric	7	1:9,759
Pharmacies	97	1:1,350
Behavioral Health Inpatient and Residential Service Providers	6	1:21,823
Behavioral Health Outpatient Assessment and Treatment Providers	2,691	1:49
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	34	1:2,010
Hospitals	140	1:936

*Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
**In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older, and pediatric providers, where the member population was limited to members 18 years of age and younger.
***High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Geographic Analysis

DHHS has set geographic access standards that require a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier.) As mentioned previously, the exception is for access to hospitals, for which the standard is defined in terms of a maximum travel time (30 minutes) from the member's residence.

Table A-17 displays the percentage of each **HBN**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table A-17—Percentage of HBN Members with Required Access to Care by Provider Type and Urbanicity

		HBN
Provider Category	**Urbanicity**	**Percentage of Members With Required Access**
PCPs	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists	Statewide	>99.9%
Neurologists	Statewide	>99.9%
OB/GYNs	Statewide	>99.9%
Oncologists/Hematologists	Statewide	99.5%
Orthopedics	Statewide	>99.9%
Pharmacies	Urban (90%)	88.8%
	Rural (70%)	39.6%
	Frontier (70%)	80.3%
Behavioral Health Inpatient and Residential Service Providers	Urban	100.0%
	Rural	100.0%
	Frontier	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	>99.9%
	Rural	100.0%
	Frontier	99.6%
Hospitals	Statewide	99.0%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table A-18 displays the percentage of **HBN**'s pediatric members who have the access to care required by contract standards for all applicable provider categories and urbanicities.

Table A-18—Percentage of Pediatric HBN Members With Required Access to Care by Provider Category and Urbanicity*

Provider Category	Urbanicity	Percentage of Members With Required Access
PCPs, Pediatric	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists, Pediatric	Statewide	99.5%
Neurologists, Pediatric	Statewide	86.6%
Oncologists/Hematologists, Pediatric	Statewide	76.2%
Orthopedics, Pediatric	Statewide	77.6%
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	Urban	79.9%
	Rural	49.7%
	Frontier	1.5%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table A-19 and Table A-20 display the percentage of **HBN**'s members with the access to care required by contract standards for behavioral health categories by Behavioral Health Region.

Table A-19—Percentage of HBN Members With Required Access to Inpatient and Residential Service Providers by Behavioral Health Region

Behavioral Health Services	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%

Behavioral Health Services	Percentage of Members With Required Access
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%

Table A-20—Percentage of HBN Members With Required Access to Outpatient Behavioral Health Services by Population and Region*

Behavioral Health Region	Percentage of Members With Required Access	Percentage of Pediatric Members With Required Access
Behavioral Health Outpatient Assessment and Treatment Providers		
Region 1	100.0%	0.0%
Region 2	99.8%	0.0%
Region 3	100.0%	0.3%
Region 4	100.0%	76.1%
Region 5	100.0%	82.2%
Region 6	100.0%	>99.9%

* Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region. The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table A-21 identifies the counties where the minimum geographic access standards were not met by **HBN** in a specific urbanicity or Behavioral Health Region for each applicable provider category, including pediatric specialists for appropriate categories. Results are presented separately for the general and pediatric populations as appropriate.

Table A-21—Counties Not Meeting Standards for HBN by Urbanicity and Behavioral Health Region

Provider Category	Counties Not Meeting Standard*
PCPs	
Urban	Lincoln
PCPs, Pediatric	
Urban	Lincoln

Provider Category	Counties Not Meeting Standard*
High-Volume Specialists**	
Cardiologists	Cherry
Neurologists	Boyd, Holt
OB/GYNs	Cherry
Oncologists/Hematologists	Cherry, Grant, Sheridan
Orthopedics	Cherry
High-Volume Specialists, Pediatric**	
Cardiologists, Pediatric	Boyd, Brown, Cherry, Holt, Keya Paha, Rock
Neurologists, Pediatric	Adams, Antelope, Banner, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Cherry, Cheyenne, Dakota, Dawes, Deuel, Dixon, Dundy, Franklin, Furnas, Garden, Garfield, Greeley, Hall, Harlan, Holt, Howard, Kearney, Keya Paha, Kimball, Knox, Loup, Madison, Morrill, Nuckolls, Phelps, Pierce, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Valley, Wayne, Webster, Wheeler
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Perkins, Phelps, Pierce, Platte, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thomas, Valley, Wayne, Webster, Wheeler
Orthopedics, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, Wheeler
Pharmacies	
Urban	Buffalo, Dakota, Dawson, Dodge, Gage, Lincoln, Madison, Platte, Sarpy, Scotts Bluff
Rural	Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Custer, Dawes, Fillmore, Furnas, Hamilton, Harlan, Holt, Jefferson, Johnson, Kearney, Keith, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Richardson, Seward, Stanton, Thayer, Thurston, Washington, Webster, York
Frontier	Arthur, Blaine, Chase, Deuel, Grant, Hooker, Sheridan, Thomas

Provider Category	Counties Not Meeting Standard*
Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Frontier	Dundy
Region 2	Dundy, Lincoln
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Adams, Buffalo, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Polk, Red Willow, Richardson, Saline, Thayer, Valley, Webster, York
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Region 1	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Region 2	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
Region 3	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
Region 4	Antelope, Boone, Boyd, Brown, Cedar, Cherry, Holt, Keya Paha, Knox, Madison, Nance, Platte, Rock
Region 5	Butler, Fillmore, Gage, Jefferson, Johnson, Nemaha, Pawnee, Polk, Richardson, Saline, Thayer, York
Region 6	Dodge
Hospitals* **	
Hospitals	Arthur, Banner, Blaine, Box Butte, Boyd, Buffalo, Cherry, Custer, Dawes, Dawson, Frontier, Gage, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Pawnee, Red Willow, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler

*Rows are only shown if at least one county did not meet the standard.
**The standard for this provider category does not differ by urbanicity.
***High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Strengths

HBN achieved 100 percent compliance with six of 12 network access standards that were presented by urbanicity, and greater than 99.0 percent compliance with an additional three of 12 standards. While **HBN** did not achieve 100 percent compliance with any of the six network access standards applied statewide, it had 99.0 percent or greater compliance for all of them. **[Access]**

HBN achieved 100 percent compliance for 11 of 12 behavioral health access standards presented by Behavioral Health Region, and 99.8 percent for the remaining standard. **[Access]**

HBN achieved at least 99 percent compliance with all access standards, except for pharmacies in urban and rural areas. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

Many **HBN** members did not have access within the standard to providers that specifically identify as having a pediatric specialty, especially with respect to behavioral health outpatient assessment and treatment providers in rural and frontier areas, where the percentages of members with access within standards are 49.7 percent and 1.5 percent, respectively. In addition, the percentage of members with access to pediatric specialists was 86.6 percent for neurologists, 76.2 percent for oncologists/hematologists, and 77.6 percent for orthopedics. For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, as contrasted with the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table A-22 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table A-22—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
HBN's greatest opportunities for improvement are to strengthen its networks of pharmacies available in rural counties and Behavioral Health Inpatient and Residential Service Providers in frontier areas.
Response
Describe initiatives implemented based on recommendations: The network directory is reviewed monthly and geo access quarterly. We currently contract with all pharmacies who are registered with the state. Additionally, **HBN** offers mail order pharmacy services for members. All behavioral health inpatient and residential service providers are contracted in the state of Nebraska. Utilization of telehealth services are encouraged in rural and frontier counties.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): We are contracted with all pharmacies who are registered with the state. We will continue to monitor for opportunities moving forward.
Identify any barriers to implementing initiatives: There are currently no additional pharmacies which are registered with the state to contract with. There is a limited number of providers in the state that offer these services. Broadband services in rural and frontier counties is not always reliable or available.
Identify strategy for continued improvement or overcoming identified barriers: We will continue to review the directory monthly and geo access quarterly. We will monitor for opportunities to contract with available pharmacies who are registered with the state. Promote the use of telehealth services for behavioral health services. We will continue to review the directory monthly and geo access quarterly. We will monitor for opportunities to contract with available pharmacies who are registered with the state.
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
HBN could significantly improve access to pediatric specialists across all provider types and regions.
Response
Describe initiatives implemented based on recommendations: Promote utilization of telehealth services in rural and frontier counties.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: Limited number of pediatricians in the state. Additionally, reliability and availability of broadband services in rural and frontier counties making it more difficult to deliver these specialty practitioners in those areas.
Identify strategy for continued improvement or overcoming identified barriers: Promote utilization of family practice providers and Live Health Online.
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.
Response
Describe initiatives implemented based on recommendations: Continued monitoring of the network for any new providers across the state.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: Barriers include lack of providers available for contracting in those areas. Additionally, there is a capacity issues of broadband services in rural and frontier counties making it more difficult to deliver these specialty practitioners in those areas.
Identify strategy for continued improvement or overcoming identified barriers: Continued monitoring of the network for any new providers across the state.
HSAG Assessment: **HBN** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Plan All-Cause Readmissions*

NTC submitted the clinical PIP, *Plan All-Cause Readmissions*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions* measure, for the CY 2023–2024 validation cycle. The PIP received an overall *Met* validation status for the initial submission. The MCE did not resubmit. Table B-1 summarizes NTC's PIP validation scores.

Table B-1—2023–2024 PIP Validation Results for NTC

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Plan All-Cause Readmissions	Initial Submission	90%	100%	*Met*
	Resubmission	*Did not resubmit*		

Overall, 90 percent of all applicable evaluation elements received a score of *Met*. Table B-2 presents baseline, Remeasurement 1, and Remeasurement 2 performance indicator data for NTC's *Plan All-Cause Readmissions* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table B-2—Performance Indicator Results for NTC's *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 175 D: 1,589	11.01%	N: 254 D: 1,942	13.08%	N: 323 D: 2,795	11.56%	*Not Assessed*

N–Numerator, D–Denominator

For the baseline measurement period, **NTC** reported that 11.01 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. For the first remeasurement period, **NTC** reported that 13.08 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The increase in the total observed readmission rate of 2.07 percentage points represented a decline in indicator performance from baseline to Remeasurement 1.

For the second remeasurement period, **NTC** reported that 11.56 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 2 rate was an improvement (decrease) of 1.52 percentage points from the Remeasurement 1 rate; however, the Remeasurement 2 rate did not improve over the baseline results. The increase of 0.55 percentage point from the baseline rate to the Remeasurement 2 rate represented a decline in indicator performance compared to initial indicator results.

Nonclinical PIP: *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*

NTC submitted the nonclinical PIP, *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*, focused on improving performance in the percentage of deliveries for **NTC** members for whom a completed NOP form was received 252 days prior to delivery for the HEDIS *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* measure, for the CY 2023–2024 validation cycle. The PIP received an overall *Met* validation status for the initial submission. The MCE did not resubmit. Table B-3 summarizes **NTC**'s PIP validation scores.

Table B-3—2023–2024 PIP Validation Results for NTC

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate	Initial Submission	100%	100%	*Met*
	Resubmission	*Did not resubmit*		

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table B-4 presents baseline and Remeasurement 1 performance indicator data for **NTC**'s *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP, which was used to objectively assess for improvement.

Table B-4—Performance Indicator Results for NTC's *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP

Performance Indicator	Baseline (01/01/2021 to 12/31/2021)		Remeasurement 1 (01/01/2022 to 12/31/2022)		Remeasurement 2 (01/01/2023 to 12/31/2023)		Sustained Improvement
The percentage of deliveries for NTC members for whom a completed NOP form was received 252 days prior to delivery.	N: 1,704 D: 3,007	56.7%	N: 1,768 D: 2,956	59.81%	N: NA D: NA	NA	*Not Assessed*

N–Numerator, D–Denominator
NA–Not Applicable

For the baseline measurement period, NTC reported that 56.7 percent of deliveries had a NOP form completed 252 days prior to delivery. For the first remeasurement period, NTC reported that 59.81 percent of deliveries had a NOP form completed 252 days prior to delivery. The increase of 3.11 percentage points demonstrated a statistically significant improvement in the NOP completion rate from baseline to Remeasurement 1.

Interventions

Clinical PIP: *Plan All-Cause Readmissions*

For the *Plan All-Cause Readmissions* PIP, NTC used brainstorming, a 5 Whys root cause analysis, and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table B-5 displays the barriers and interventions documented by the health plan for the PIP.

Table B-5—Barriers and Interventions for the *Plan All-Cause Readmissions* PIP

Barriers	Interventions
Lacking support for members post-discharge.	Outreach members to complete a TOC assessment form, which is used to identify post-discharge member needs. The outreach includes discharge education review, invitation to enroll in case management, assisting with follow-up appointment scheduling, and offering transportation assistance.
Referral and outreach process and staffing in need of improvement.	Training utilization management (UM) staff on appropriate care management (CM) referral and outreach processes.
Lack of provider awareness on HEDIS *PCR* specifications and measure requirements.	Educating providers by sharing *PCR* data, feedback, and tips for improving the HEDIS *PCR* rate.

Barriers	Interventions
Additional support needed to reduce readmissions for members with behavioral health (BH) diagnoses.	Partnering with University of Nebraska Medical Center (UNMC) to provide outreach to reduce readmission risk for members diagnosed with schizophrenia.
	Updating the TOC plan to ensure BH staff outreach members with BH diagnoses prior to and post discharge.

Nonclinical PIP: *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*

For the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP, **NTC** used brainstorming, a 5 Whys root cause analysis, and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table B-6 displays the barriers and interventions documented by the health plan for the PIP.

Table B-6—Barriers and Interventions for the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP

Barriers	Interventions
Unable to reach members who may be pregnant.	Automated outreach calls and emails delivered to members listed on the 413 report (possible pregnancy report) encouraging NOP completion, if applicable.
Lack of provider participation in obtaining NOPs.	Targeted messaging to remind providers of incentive for NOP completion: eNews article, provider presentations, and via Provider Representative (PR) team.
Members not motivated by original incentive amount to complete NOP.	Revised and increased member incentive for NOP completion in 2023.
Providers need reminders to complete NOPs.	Developed strategic plan for provider education on NOP incentive for 2023.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **NTC** followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **NTC** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **NTC** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**

- NTC reported Remeasurement 1 indicator results for the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP that demonstrated statistically significant improvement over baseline results. **[Quality and Timeliness]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG identified the following opportunity for improvement:

- NTC reported Remeasurement 2 indicator results for the *Plan All-Cause Readmissions* PIP that demonstrated a decline in performance improvement from baseline despite an improvement from Remeasurement 1. **[Quality]**

To address the opportunity for improvement, HSAG offers the following recommendations for NTC:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table B-7 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table B-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
Opportunity for Improvement: NTC reported indicator results that demonstrated a decline in performance from baseline to Remeasurement 1.
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Response
Describe initiatives implemented based on recommendations: After receiving the PIP (Performance Improvement Project) from the state of Nebraska – and not meeting the 2021 goal, the team huddled for evaluation, discussion, and planning. Members included: CMO (Chief Medical Officer), Vice President, PHM/UM, Vice President, Quality, Director PHM/CM, Sr. Manager/Quality, Sr.

Health Equity Specialist / Quality, Quality Improvement Coordinator, Manager, Behavioral Health, Quality Data Analyst, and Manager, Utilization Management Concurrent Review.

The number of PCR (Plan All-Cause Readmissions) hospitalizations from baseline to 2021 increased by 353 admissions. The number of observed 30-day re-admissions rose from 175 to 254, resulting in 79 more observed re-admissions in 2021 as compared to the 2019 baseline. This, in turn, influenced the PCR observed readmission rate with an increase of 2.07 percentage points. Due to the linear increase of hospitalizations as well as observed and expected re-admission from baseline to remeasurement year 1, the p value equals 0.0625 and is not considered statistically significant.

From this meeting, it was requested to have the PCR data analyzed further to help identify any areas of opportunity. Data findings included: The main re-admission diagnoses evolved around behavioral health; the primary age group: 18 – 44 years of age and the Readmission timeline: within 12-15 days. PCR Data findings reviewed with PCR PIP group listed above and 5 Why's completed.

Root cause identified: Members with higher readmission probability (those with Behavioral Health, Diagnosis) need individualized support and outreach.

Interventions to remove root cause:

1. Support members with high readmission – UNMC Collaboration Schizophrenic Pilot
2. Establish and build a relationship with the Behavioral Health members; start prior to discharge if possible – September 2022: BH/TOC (Transition of Care) Position

The PCR PIP was placed into the A3 format for tracking purposes. A Microsoft Teams Channel for the PIP team was set up in April for continued communication between the teams. Additionally, a PIP Round Table began meeting monthly in July 2022.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PCR rate after implementing interventions in MY2022 declined by 1.52% with the final rate of 11.56% (remeasurement 2) as compared to 13.08% (remeasurement 1).

Identify any barriers to implementing initiatives:
The first candidate for the BH/TOC fell through, so the intervention did not take place until September 2022. However, the rate from Q3, 12.42%, was reduced to 11.56% in Q4.

Identify strategy for continued improvement or overcoming identified barriers:
BH/TOC position is maintained as a crucial piece of our case management team. Other team members are also now trained in the workflows of this position to assist, as needed, with an increased workload.

HSAG Assessment: **NTC** sufficiently addressed the CY 2022–2023 recommendations.

Recommendations

Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.

Response

Describe initiatives implemented based on recommendations:
The quality department staff went through A3 training via IHI (Institute for Healthcare Improvement) videos and lecture.
The 5 Why's was implemented as primary source of identifying root cause in process improvement work.
The PDSA (Plan, Do, Study, Act) cycle is used in the A3 process and implemented as a primary tool to review data and implement necessary changes when needed.
As stated above the PIPs (Performance Improvement Projects) were moved to A3 format for following and an ongoing roundtable set up for review, discussion, and evaluation.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Utilizing the A3 template has organized tracking of root cause, barriers, action steps, data, analysis, and evaluation to one consolidated document.
Identify any barriers to implementing initiatives: Knowledge deficit of staff initially utilizing A3 form
Identify strategy for continued improvement or overcoming identified barriers: Barrier overcome by continued education and use of the A3 forms within and outside of the quality department.
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.
Response
Describe initiatives implemented based on recommendations: Establish and build a relationship with the Behavioral Health members; start prior to discharge if possible – September 2022: BH/TOC (Transition of Care) Position
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Members with the BH TOC staff support prior to and post discharge had a 99.17% success in not having an unexpected readmission (Q4 2022)
Identify any barriers to implementing initiatives: Barrier – if staff exited or was out of office
Identify strategy for continued improvement or overcoming identified barriers: Cross trained staff to be able to take this workload if BH/TOC staff was gone.
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Measures

Results for Information Systems Standards Review

The table below provides a summary of NTC's key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix E* of this report.

Table B-8—Summary of Compliance With IS Standards for NTC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured.	The LO determined that NTC was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that NTC only accepted industry standard codes on industry standard forms.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
• Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed and steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	All data elements required for HEDIS reporting were adequately captured.
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCEs continually assess data completeness and take steps to improve performance. • The MCEs effectively monitor the quality and accuracy of electronic submissions. • The MCEs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**NTC** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **NTC** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**NTC** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **NTC** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **NTC** reviewed all provider data received from delegated entities.
IS 4.0—MRR Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**NTC** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy.	**NTC** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in nonstandard form that required PSV.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
• Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for ECDS reporting met reporting requirements. • NCQA validated data resulting from the DAV program met reporting requirements.	
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**NTC** was compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by **NTC**'s staff members. Data were verified for accuracy at each data merge point.
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**NTC** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA-certified measure vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by NTC. According to the DHHS's required data collection methodology, the rates displayed in Table B-10 reflect all final reported rates in NTC's IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that NTC may have received an "NA" status for an indicator due to a small denominator within the measure but still have received an "R" designation for the total population.

Table B-9—HEDIS Audit Results for NTC

Audit Finding	Description	Audit Result
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	***R***
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	***NA******
The MCO did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	***NB****
The MCO chose not to report the measure.	Not Reported	***NR***
The MCO was not required to report the measure.	Not Required	***NQ****
The rate calculated by the MCO was materially biased.	Biased Rate	***BR***
The MCO chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).	Unaudited	***UN***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table B-10—NTC's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
Effectiveness of Care: Prevention and Screening				
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	64.39%	69.34%	70.80% ★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	56.34%	55.96%	65.69% ★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	60.00%	57.18%	67.64% ★★	R
CIS: Childhood Immunization Status—Combination 3	69.10%	70.07%	71.29% ★★★★	R
CIS: Childhood Immunization Status—Combination 7	—	61.56%	63.26% ★★★★	R
CIS: Childhood Immunization Status—Combination 10	49.64%	47.45%	42.82% ★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, toxoids and acellular pertussis [Tdap])	74.94%	78.10%	78.35% ★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	—	33.33%	27.49% ★	R
LSC: Lead Screening in Children	69.97%	68.94%	68.15% ★★★	R
BCS: Breast Cancer Screening	47.94%	54.48%	54.65% ★★★	R
CCS: Cervical Cancer Screening	63.16%	58.39%	61.80% ★★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20	26.96%	28.02%	31.45% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24	42.01%	44.46%	42.16% ★	R
CHL: Chlamydia Screening in Women—Total	32.17%	34.22%	36.07% ★	R
Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	71.04%	70.31%	69.03% ★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	63.24%	63.08%	63.02% ★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65+	NA	NA	NA	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
CWP: Appropriate Testing for Pharyngitis—Total	69.77%	68.15%	67.15% ★★	R
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	16.67%	22.41%	28.03% ★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	75.82%	72.20%	72.50% ★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	89.54%	87.89%	82.50% ★★	R
AMR: Asthma Medication Ratio—Ages 5 to 11	81.51%	83.71%	82.67% ★★★★	R
AMR: Asthma Medication Ratio—Ages 12 to 18	73.47%	72.69%	74.78% ★★★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	65.84%	62.29%	72.22% ★★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	63.51%	59.26%	75.81% ★★★★★	R
AMR: Asthma Medication Ratio—Total	73.71%	71.99%	75.92% ★★★★★	R
Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure	63.75%	61.31%	67.64% ★★★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	76.67%	87.23% ★★★★	R
Effectiveness of Care: Diabetes				
HBD: Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Control (<8.0%)	47.20%	51.82%	52.07% ★★	R
*HBD: HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)**	44.28%	39.90%	36.74% ★★★	R
BPD: Blood Pressure Control for Patients With Diabetes	63.02%	66.91%	69.59% ★★★	R
EED: Eye Exam for Patients With Diabetes	57.18%	57.66%	58.39% ★★★	R
Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.05%	64.57%	62.14% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	39.41%	47.12%	45.37% ★★★	R
ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	46.33%	40.68%	43.99% ★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	61.05%	48.39%	54.15% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	48.11%	46.12%	60.04% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	71.64%	68.98%	78.59% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	35.24%	29.22%	35.06% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	55.87%	47.10%	54.78% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	40.52%	34.49%	42.09% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.45%	53.92%	61.43% ★★★	R
FUM: Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total	48.36%	43.33%	39.42% ★★	R
FUM: Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	65.37%	61.39%	59.61% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)—7-Day Follow-Up—Total	28.31%	25.08%	29.56% ★★	R
FUI: Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	45.18%	42.52%	47.50% ★★	R
FUA: Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total	—	—	29.34% NC	R
FUA: Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	—	—	43.47% NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.29%	80.96%	79.60% ★★★	R
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	70.20%	65.48%	61.82% ★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.11%	64.82%	61.39% ★★★	R
Effectiveness of Care: Overuse/Appropriateness				
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.70%	0.64%	0.48% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	87.51%	89.58%	89.72% ★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64	76.08%	79.40%	81.86% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65+	NA	NA	NA	R
URI: Appropriate Treatment for Upper Respiratory Infection—Total	85.98%	87.75%	88.04% ★	R
LBP: Use of Imaging Studies for Low Back Pain—Total	—	—	74.09% NC	R
*HDO: Use of Opioids at High Dosage**	5.59%	2.39%	2.04% ★★★	R
Access/Availability of Care				
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 13 to 17	—	—	29.91% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 13 to 17	—	—	12.25% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 18 to 64	—	—	39.97% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 18 to 64	—	—	12.62% NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 65+	—	—	NA	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 65+	—	—	NA	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total	—	—	38.98% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total	—	—	12.57% NC	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	76.89%	77.86%	83.45% ★★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	73.24%	76.16%	79.08% ★★★	R
Utilization[2]				
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.60%	65.23%	67.06% ★★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.47%	67.85%	70.09% ★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total^**	484.44	626.52	641.26 ★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^*	3,776.64	4,329.72	4,312.27 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total^*	82.8	82.08	69.52 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total	4.59	5.08	5.44 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total^*	68.76	47.64	38.41 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total	2.53	2.66	2.65 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total^*	13.92	17.88	16.37 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total	10.21	9.59	10.51 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total^*	29.4	33.96	27.68 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total	4.68	4.87	5.01 NC	R
Risk Adjusted Utilization				
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	11.66%	13.08%	11.61% NC	R
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	10.86%	10.90%	10.83% NC	R
*PCR: Plan All-Cause Readmissions—Observed to Expected (O/E) Ratio—Total**	1.07	1.20	1.07 ★	R
Measures Collected Using Electronic Clinical Data Systems				
BCS-E: Breast Cancer Screening	—	—	54.41% NC	R

[1] Due to changes in percentile rankings represented in star ratings between MY 2021 and MY 2022, star ratings are displayed for MY 2022 only.
[2] In the Utilization domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for informational purposes only.
* For this indicator, a lower rate indicates better performance.
^ For this indicator, the rate is reported per 1,000 member months rather than a percentage.
NA indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2022 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-11—NTC's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
Adult Core Measures			
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	33.20%	37.93%	57.44%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 18 to 64**	—	3.53%	1.89%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+**	—	1.41%	0.00%
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 18 to 64[1]	—	—	—
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 65+[1]	—	—	—
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 18 to 64 Years**	—	21.31%	18.43%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 65 Years and Older**	—	16.25%	16.18%
Child Core Measures			
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 1 Year	—	24.22%	25.89%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 2 Years	—	31.23%	32.80%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 3 Years	—	29.72%	28.61%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	28.26%	29.05%
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17[1]	—	—	—
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Most or moderately effective contraception (MMEC)—within 3 days of delivery	—	—	1.98%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—MMMEC—within 90 days of delivery	—	—	40.48%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Long-acting reversible method of contraception (LARC)—within 3 days of delivery	—	—	1.59%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—LARC—within 90 days of delivery	—	—	20.63%

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—MMEC	—	—	28.50%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—LARC	—	—	4.70%

[1] The CMS Adult and Child Core Set measures *CDF-AD* and *CDF-CH* were purposely excluded from the template DHHS supplied to the MCO for Core Measures reporting. The MCO did not report on these measures for the MY 2022 period.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year(s).

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*; *Lead Screening in Children*; *Breast Cancer Screening*; and *Cervical Cancer Screening* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for the *Childhood Immunization Status—Combination 3*, *Combination 7*, *and Combination 10* and *Cervical Cancer Screening* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for the *Lead Screening in Children* and *Breast Cancer Screening* measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. The *Lead Screening in Children* rate demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they maintained limited exposure to lead. The *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 years were receiving screening for one of the most common causes of cancer death in the United States. Lastly, the *Breast Cancer Screening* rate demonstrates that women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years. **[Quality, Timelines, and Access]**

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 5 to 11*, *Ages 12 to 18*, *Ages 19 to 50*, *Ages 51 to 64*, and *Total*, and *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for these measure indicators. The *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator was also a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The *Asthma Medication Ratio* rates demonstrate that **NTC** providers effectively managed this treatable condition for members with persistent asthma. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* rate demonstrates that **NTC** providers were conducting spirometry testing to diagnose COPD, as recommended by the Global Initiative for

Chronic Obstructive Lung Disease. [B-1] Lastly, the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* rate demonstrates that **NTC** providers were appropriately prescribing medication to help members control their COPD. **[Quality and Access]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure and *Persistence of Beta-Blocker Treatment After a Heart Attack* measure were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for both measures. The *Controlling High Blood Pressure* rate demonstrates that **NTC** providers helped members manage their blood pressure, reducing their risk for heart disease and stroke. Additionally, the *Persistence of Beta-Blocker Treatment After a Heart Attack* rate demonstrates that **NTC** providers ensured that members who have had a heart attack receive persistent beta blocker treatment following the heart attack to improve health outcomes. **[Quality and Timeliness]**

Effectiveness of Care: Diabetes Domain

The *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*, *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)*, and *Eye Exam for Patients With Diabetes* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *HbA1c Poor Control (>9.0%)* rate demonstrates that **NTC** providers helped members effectively control their blood glucose levels, reducing the risk of complications. The *Blood Pressure Control for Patients With Diabetes* rate demonstrates that **NTC** providers helped adult members with diabetes adequately control their blood pressure. Lastly, the *Eye Exam for Patients With Diabetes* rate demonstrates that **NTC** providers ensured that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

For the following measure indicators, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* **[Quality]**
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* **[Quality, Timeliness, and Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64, and Total) and 30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64, and Total)* **[Quality, Timeliness, and Access]**

[B-1] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease."

- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **[Quality and Access]**

The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* rates demonstrate that **NTC** providers were effectively treating adult members diagnosed with major depression by prescribing antidepressant medication and helping them remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**

The *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* rate demonstrates that **NTC** providers ensured that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that **NTC** providers ensured that members hospitalized for mental illness received adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* rate demonstrates that **NTC** providers effectively managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Lastly, members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rate demonstrates that **NTC** providers effectively ensured that adult members on antipsychotics were screened for diabetes, resulting in positive health outcomes for this population. Additionally, the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rate demonstrates that **NTC** providers ensured that members with schizophrenia or schizoaffective disorder adhered their treatment plan and continued to use prescribed antipsychotic medications. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64* and *Use of Opioids at High Dosage* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64* rate demonstrates that, for adult members, **NTC** providers effectively managed the dispensing of antibiotic medication to treat URI. The *Use of Opioids at High Dosage* rate demonstrates that **NTC** providers prevented or minimized the prescribing of opioids at a dosage of ≥ 90 mg morphine equivalent dose. **[Quality]**

Access/Availability of Care Domain

The *Prenatal and Postpartum Care—Postpartum Care* measure indicator was a strength for **NTC**. **NTC**'s rates for this measure indicator ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark. The rate for this measure indicator demonstrates that **NTC** providers ensured that members received timely and adequate postpartum care, in alignment with guidance provided by the AAP and the ACOG. **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The rates for these measure indicators show that **NTC** providers ensured that children were seen by a PCP within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**

Risk Adjusted Utilization Domain

HSAG did not identify any strengths when conducting the PMV for **NTC** within the *Risk Adjusted Utilization* domain.

Measures Collected Using Electronic Clinical Data Systems Domain

HSAG did not identify any strengths when conducting the PMV for **NTC** within the *Measures Collected Using ECDS* domain.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. HSAG recommends that **NTC** and its providers strategize the best way to use every visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, HSAG recommends that **NTC** providers follow up annually with sexually active members through various modes of communication to ensure members return for yearly screening. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for **NTC**. **NTC**'s rate for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. The rate for this measure indicator suggests that child and adolescent members did not receive proper testing to merit antibiotic treatment for pharyngitis. HSAG recommends that **NTC** work with providers to determine whether children and adolescents are being properly tested to prevent the unnecessary use of antibiotics. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the *Effectiveness of Care: Cardiovascular Conditions* domain.

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the *Effectiveness of Care: Diabetes* domain.

Effectiveness of Care: Behavioral Health Domain

The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure. The rate for this measure suggests that **NTC** providers were not properly monitoring the status of members with diabetes that used antipsychotics. HSAG recommends that **NTC** review its data production process for these measures to ensure no claims are missing and all available data are being collected for the measures. **NTC** might also consider performance-based incentives for its behavioral health provider network to ensure that all providers are adequately monitoring and supporting high-risk members. **[Quality]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Total* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark on these measure indicators. The rates for these measure indicators suggest that a diagnosis of URI resulted in an antibiotic dispensing event for members 3 months to 17 years old. HSAG recommends that **NTC** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommends that **NTC** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the *Access/Availability of Care* domain.

Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the *Utilization* domain.

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. HSAG recommends that **NTC** work with its providers to ensure diagnosis and treatment of members are complete and precise to improve readmission rates. **[Quality]**

Measures Collected Using Electronic Clinical Data Systems Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the *Measures Collected Using ECDS* domain.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table B-12—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for Prevention and Screening Domain
• The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* measure indicators were a weakness for **NTC**. For these measure indicators, **NTC**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. According to NCQA (as cited by the American Heart Association), child obesity has more than doubled over the last three decades and tripled in adolescents. HSAG continued to recommend that **NTC** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. If the rate in children and adolescents receiving these services is identified to be related to the continuation of the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services.
• The *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were also a weakness for **NTC**. For these measure indicators, **NTC**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1 Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic. HSAG continued to recommend that **NTC** providers follow up annually with sexually active members through any type of communication such as emails, phone calls, or text messages to ensure

members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuing COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for ensuring ongoing access to these important services.

Response

Describe initiatives implemented based on recommendations:

WCC BMI, Exercise and Nutrition Counseling: The WCC measures are a priority for Nebraska Total Care and placed into providers' contracts as a Paid for Performance measure in 2022 and 2023. This is a provider incentive program designed to improve & reward providers' performance around patients' health care & the specific activities related to quality indicators, most commonly: HEDIS, risk-adjustment, access, member engagement and continuity of care. Monthly scorecards and Gap in care reports are shared with the providers and reviewed. Tips for improving care gaps are discussed, review of value-add benefits to assist providers to close gaps are also reviewed. Additionally, a provider education and leave behind flyer was created for the WCC measure covering both documentation and coding needs for closure. WCC was reviewed in all Value Based Contract (VBC) and Joint Operating Committee (JOC) meetings and additionally quality practice advisor meetings, sharing the providers' current rates as well as offering tips from our HEDIS® Quick Reference Guide. A project to capture CPT (Current Procedural Terminology) II codes using penny claims was initiated in 2022 and expanded in 2023. As far as data opportunities, BMI EMR charts during Hybrid were analyzed, and findings showed that many of the charts contained the height and weight but did not have the percentile documented or documentation was not pulled appropriately during chart submission. Provider education was provided to assist in improved rates for MY2023. Data sources for supplemental files were analyzed for appropriate mapping and ingestion. Source files have increased in MY2023 and WCC additionally continues to be abstracted within our internal year-round chart chase. Providers submit medical record evidence in provider portal submissions to assist with Provider Incentives. WCC continues to be a hybrid chart chase for end of year rates, opportunities were evaluated at end of hybrid chase to evaluate opportunities for charts not able to obtain at end of project. Opportunities are identified annually to improve the Hybrid project and chase initiatives. **NTC** developed and scheduled a HEDIS Education Summit in October to educate provider team members on appropriate documentation and chart abstraction to ensure a compliant WCC measure. Supplemental data education was provided to ensure the capturing of Source data in MY2022; In MY 2023, all Source (SDS (Supplemental Data Systems)) files were analyzed to ensure BMI data was captured. EMR access is available for certain health systems – abstraction of charts was initiated in MY2022 and has been expanded in MY2023. PR & Network team evaluating additional EMR access from providers in MY2023 and ongoing.

CHL: CHL is included separately, as well as within our complete well woman messaging to targeted ages of women throughout the calendar year. Outreach messaging is launched via various platforms to reach as many members as possible. These platforms include Emails, Texts, and Proactive Outreach Manager (POM) calls. The Q4 member newsletter also contains a section specific to women's health and includes the importance of chlamydia testing. The health plan often receives clinical evidence of CHL when providers submit Notification of Pregnancy (NOP) and Obstetric Needs Assessment Forms (ONAF) to the health plan. These records are utilized for chart abstraction to look for CHL completion during prenatal screening. Additionally, all prenatal records captured during year- round and hybrid chart chases are reviewed for CHL inclusion. The CHL measure was also placed into providers' contracts as a Paid for Performance measure in 2022 and currently in 2023. This is a provider incentive program designed to improve & reward providers' performance around patients' health care & the specific activities related to quality indicators, most commonly: HEDIS, risk-adjustment, access, member engagement and continuity of care. Monthly scorecards and Gap in care reports are shared with the providers and reviewed. Tips for improving care gaps are discussed, review of value-add benefits to assist providers to close gaps are also reviewed. CHL is a Hybrid chart chase and Hybrid opportunities and enhancements are made on previous years chase performance. In MY 2023, all Source (SDS)

files were analyzed to ensure data mapping and all source data was captured. EMR access is available for certain health systems – abstraction of charts was initiated in MY2022 and are being expanded in MY2023. PR & Network team evaluating additional EMR access from providers in MY2023 and ongoing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): MY22 increases over MY21 WCC BMI: +1.49% WCC Nutrition: +7.0% WCC Physical: +10.46% CHL: +1.85% Per the September Run 1 2023 HEDIS run WCC- BMI: 8.33% above the prior year at this same time WCC – Nutrition: 8.24% above prior year at this same time WCC – Physical Activity: 4.60% above prior year at this same time CHL – 0.58% above prior year at this same time
Identify any barriers to implementing initiatives: WCC BMI –Documentation of BMI is not always as a percentile within the chart; Not all providers have the EMR updated system to process CPT II coding within the EMR systems. WCC Exercise and Nutrition – Not all documentation is meeting components necessary to close. CHL – Nebraska historically as a state does poorly with CHL Many young people utilize free clinics for STD testing and therefore health plans do not receive data to show gap closure. An additional barrier to CHL will be the new FDA approval of the first over-the-counter oral contraceptive able to be obtained without a prescription – resulting in many sexually active members not utilizing a provider to obtain the prescription and therefore testing is not completed.
Identify strategy for continued improvement or overcoming identified barriers: WCC all – Continued provider education: The WCC measures will be included in Nebraska Total Care's provider HEDIS Summit to review the measures and guidelines for data submission of appropriate evidence to close. HEDIS team will CHL – Nebraska Total Care will continue to outreach for our female members with targeted messaging for their preventative health: CHL, CCS, BCS. Any member that enters our case management services, such as Start Smart for Your Baby®, has care gaps reviewed and assisted with closure.
HSAG Assessment: **NTC** sufficiently addressed the CY 2022–2023 recommendations regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators. **NTC**'s performance on these measure indicators improved from MY 2021 to MY 2022 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. **NTC** did not sufficiently address the CY 2022–2023 recommendations for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. **NTC**'s performance on this measure indicator improved from MY 2021 to MY 2022; however, the MY 2022 rate on this indicator remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **NTC**'s work with providers to identify and address care gaps impacting performance on this indicator and recommends that **NTC** continue these efforts. **NTC** did not sufficiently address the CY 2023–2023 recommendations for the *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators. **NTC**'s performance on two of the three indicators improved from MY 2021 to MY 2022; however, the MY 2022 rates for all three indicators fell below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **NTC**'s outreach campaigns to encourage sexually active women members to receive a chlamydia

screening and NTC's work with providers to identify and address care gaps. HSAG recommends that NTC continue these efforts to improve performance on these indicators.

Recommendations for Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for NTC. For this measure indicator, NTC's rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. HSAG continued to recommend that NTC conduct a root cause analysis for the *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator to determine why members are not being tested. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics. If the low rate in members accessing these services is identified as related to the continuation of the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for ensuring ongoing access to these important services.

Response

Describe initiatives implemented based on recommendations:
NTC conducted a root cause analysis for the Appropriate Testing for Pharyngitis measure to further understand the data of the CWP population of compliant and non-compliant.
Findings included: Providers utilizing the J020 and J0300 codes, which include the terminology of streptococcal within the definition, the rate of compliance is 82.63% (J0300) and 90.41% (J020).
The diagnosis of [J03.80] Acute tonsillitis due to other specified organisms, performed the lowest at 39.13%, followed by [J03.91] Acute recurrent tonsillitis, unspecified at 42.86%
Additionally, 2 primary provider groups show a trend of diagnosing with J02.8, Acute pharyngitis due to other specified organisms and J02.9, Acute pharyngitis, unspecified and are not testing members.
Provider education on appropriate testing was complete and will be repeated in Fall 2023 as respiratory illnesses rise.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
CWP from MY21 to MY22 dropped 1.0% However, year to date CWP rate is 78.81%, almost 12% above the rate at this time last year. The current denominator is more than double the previous year, with the rate at a 4 star; if continue the current trajectory will be a 5 star.

Identify any barriers to implementing initiatives:
Reaching the practicing providers with education

Identify strategy for continued improvement or overcoming identified barriers:
NTC utilizes several modalities to provide education: PowerPoints at VBC presentations, e-News, provider newsletters, direct conversations with provider relation representatives or quality practice advisors.

HSAG Assessment:
NTC did not sufficiently address the CY 2022–2023 recommendations regarding the *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator. NTC's performance on the *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator declined from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes NTC's work with providers to encourage appropriate testing for pharyngitis and recommends that NTC continue these efforts.

Recommendations for Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Total* measure indicators were a weakness for NTC. For these measure indicators, NTC's rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommended that NTC conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the

danger of antibiotic-resistant bacteria. In addition, HSAG recommended that providers evaluate their noncompliant claims to ensure that there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.

Response

Describe initiatives implemented based on recommendations:
Data analysis shows that the rate in the subgroup of 3-17 years of age has been stagnant over the last few years; 18–64-year-old improved in MY22. However, 65+ members in the URI population have had a steady decline year-over-year.
Provider messaging during flu season was included in eNews and the provider newsletter as well as at key provider touchpoints such as provider meetings. Antibiotic stewardship campaigns were also of note for provider education.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
URI Total improved from MY21 to MY22 by 0.29%
Further analysis of the stagnant rate in the subgroup 3–17-year-olds and the increase in the 65+ year olds is noted as an opportunity for further data analysis and is being completed.

Identify any barriers to implementing initiatives:
Providers often get pressure from patients / patient guardians to treat.

Identify strategy for continued improvement or overcoming identified barriers:
Continued education on both the provider and member side

HSAG Assessment:
NTC did not sufficiently address the CY 2023–2023 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator. **NTC**'s performance on the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was consistent from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **NTC** work with providers to encourage the appropriate prescribing of antibiotics and recommends that **NTC** continue these efforts.

Recommendations for Access/Availability of Care Domain

- The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD (Alcohol or Other Drug) Treatment—Total—Ages 13 to 17* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care. HSAG continued to recommend that **NTC** work with its providers to ensure they are reaching members with identified SUD and to engage in follow-up treatment. **NTC** might consider working with providers to illustrate the time sensitivity of the measure requirements and ask providers about their strategies for engagement in treatment.
- The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator was also a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Studies indicate that as many as 60 percent of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care, and made changes in their health and lifestyle habits.[B-2] Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their

[B-2] CDC Review to Action. (2018). Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees.

infants. HSAG recommended that **NTC** work with its providers on best practices for providing ongoing prenatal care. This is especially important during the continuation of the COVID-19 PHE, as pregnant and recently pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women.

Response

Describe initiatives implemented based on recommendations:

IET initiation / engagement

2022: **NTC** worked with its provider community on a variety of platforms: Education was added to the Provider Newsletter specific to IET; Education was provided to the Behavioral Health Case Management team by Quality staff to ensure as the worked with both members and providers, the CM (Case Management) team understood the measure and specifications. Provider Health Sheets for IET were created by our marketing team for use by our provider relations teams going out to offices. Additional content on IET was added to our provider website; **Nebraska Total Care**'s MCO shared specific IET information at VBC and JOC meetings.

2023:

Case management staff completed training on IET online; Quality presented education at the case management team meeting and added content again within the case management e-news

Opportunities were explored with a peer-to-peer and SUD support vendor out of Ohio as well as a SUD support provider in Nebraska – halted implementation

The Admission, Discharge and Transfer (ADT) report from three primary behavioral health facilities was turned on for utilization in member outreach

Behavioral Health Manager and Case Management staff going to facilities prior to member discharge to help with follow-up appointments and removing and SDOH (Social Determinants of Health) barriers for post-discharge success.

Data analysis of IET measure population.

PPC-t

2022: **NTC** began a performance improvement project in the field of increasing the number of Notifications of Pregnancy (NOPs) This form, completed by member, provider, or health plan staff allows for identification of a pregnant member for the health plan to outreach to offer education and support. Earlier identification allows for earlier outreach in the member's pregnancy to assist in the member seeing her provider in a timely manner. Nebraska Total Care used educating providers on the incentive for NOP completion to also educate providers on timely prenatal care and postpartum appointments. Messaging was shared at provider meetings and town halls, via e-news, within provider newsletters and one on one presentations.

Hybrid measure due to no claims for prenatal care (bundle billing state) – hence began year-round chart abstraction. The health plan also conducts in house retrieval of charts using EMR access from provider sources that have allowed access.

2023: Increased member incentive for NOP completion; continued provider education on NOP/ONAF completion and PPC-t/pp education tips on closure.

PPC measures were also placed into providers' contracts as a Paid for Performance measure in 2022 and currently in 2023. This is a provider incentive program designed to improve & reward providers' performance around patients' health care & the specific activities related to quality indicators, most commonly: HEDIS, risk-adjustment, access, member engagement and continuity of care. Monthly scorecards and Gap in care reports are shared with the providers and reviewed. Tips for improving care gaps are discussed, review of value-add benefits to assist providers to close gaps are also reviewed. Due to state global billing, **NTC** continues to have PPC-t and PPC-pp as a hybrid measure. Throughout the year, **NTC** also conducts a year- round chart chase on PPC measures – using EMR systems and end of your chart chase request to increase rates.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
IET initiation / engagement
MY22 had a decline over MY2021.
Understanding the IET technical specifications and the IET data has led to further investigation of how members are getting into the denominator multiple days in a row.

PPC-t
MY22 improved over MY21 by 5.59%
(PPC-pp also improved by 2.92% in MY22 as compared to MY21)

Identify any barriers to implementing initiatives:
IET initiation / engagement
Due to the short timeline from diagnosis to treatment initiation, the health plan is challenged with identifying these members quickly with claims data to support them getting into follow-up appointments. The ADT feed was not fully functioning all of 2023 and there was also a delay with turning on the 3 behavioral health facilities until August 2023.
Data analysis and IET technical specification understanding of how it is fed into our HEDIS engines is a complex process. Barrier is finding the right staff on our corporate team to offer assistance.

PPC-t
In the state of Nebraska, obstetrical care is bundled within one bill post-delivery resulting in no claims history during the pregnancy.

Identify strategy for continued improvement or overcoming identified barriers:
IET initiation / engagement
Nebraska Total Care has made the move in 2023 to get out and partner with BH facilities for in-person representation by **NTC** staff and will continue to do so into 2024.
Doing a deep dive into our IET population, **NTC** found members landing in the IET denominator multiple times in consecutive days (one, for instance, 23 days in a row). This finding was escalated to our HEDIS team at Centene, our parent company. Performing a deep dive on this specific member resulted in the awareness that in Nebraska the providers are utilizing the billing code H0011 to get paid for this service in this population. Even with the member being inpatient, which should move the member to compliance per the specs, the code that providers have been instructed to utilize (for payment/fee schedule) this code is an outpatient code and places the member in the denominator but does not move them to the numerator. The HEDIS engine is picking up the code correctly per the set of meeting the technical specifications. With this coding **NTC** is not able to ask the provider to change how they bill. Next step was to escalate this to the Centene Custom Measure Team to discuss setting up a custom measure for Nebraska on IET. Next steps will be to meet with Attest auditors with a business case presentation; corporate compliance will set up the meeting.

PPC-t
NOP / ONAF provider and member incentive to identify pregnant members.
Year-round chart abstraction for PPC-t and PPC-pp using EMR access, provider record portal submissions and a year round chart chase with chase vendor Ciox in Q4 of measurement year.
Optimizing Hybrid chases for MY2023 by evaluating charts missed in MY2022 and strategizing some in house chart retrievals.
The discussion of unbundling obstetrical care has been brought to MLTC for discussion with the other MCOs – but no movement on unbundling has taken place at this time.
NTC is considering removing the NOP/ONAF provider incentive in 2023 and moving towards an incentive for the first prenatal record submitted to the health plan.

Continue to partner with MLTC and regional partners on promoting early access into Medicaid for members who are pregnant and uninsured.

HSAG Assessment:
The technical specifications for the *Initiation and Engagement of SUD Treatment* measure underwent major changes in MY 2022. Therefore, MY 2022 results for this measure are not comparable to MY 2021 results. **NTC** sufficiently addressed the CY 2022–2023 recommendations regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. **NTC**'s performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator improved from MY 2021 to MY 2022 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

Recommendations for Utilization Domain

The *Ambulatory Care—ED Visits—Total* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked at or below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark, suggesting higher utilization of services. HSAG recommended **NTC** conduct a root cause analysis of why this rate changed significantly from last year and determine what actions should take place in order to improve the rate.

Response

Describe initiatives implemented based on recommendations:
MY2022 Nebraska Total Care was not successful in reducing utilization by at least 5% over the prior year. When comparing year over year the results show emergency room utilization increased by 11.60 percent.

The utilization results were evaluated. The Patient safety or outcomes across settings focus area is not having the desired level of impact as indicated by missing the stated goal.

Qualitative Analysis
The results for the utilization measures are reviewed by a multi-disciplinary group that includes Medical Directors and members of the QI, UM, CM, and Provider Engagement departments as part of the Clinical Advisory Counsel and Quality Assurance and Performance Improvement Committee. Drivers of ED overuse may include lack of access to timely primary care services, referral to the ED by primary care physicians themselves, and financial and legal obligations by hospitals to treat all patients who arrive in the ED. Overutilization and overreliance on EDs as a usual source of care may lead to unnecessary high costs and undesirable consequences, such as a gap in care coordination and inadequate provision of preventive care. Strategies to curb ED overuse may include improve access and scheduling; providing alternative sites for non-urgent primary care; improving the case management of chronic disease patients, and using financial incentives and disincentives for visits to the ED. According to a National Library of Medicine [1] study this may reflect that the ED provides unique care that other health care venues do not typically offer, such as continuous care without restricted hours of operation
[1] National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5363893/

Opportunity 1: Increase frequency of contact and coordination with members prior to and post-discharge
Intervention: Nebraska Total Care will identify a specific staff member to outreach to discharge planners prior to member discharge and members post-discharge to ensure follow up with scheduled appointments, ways to help members overcome barriers to care, and engage members with care.
Opportunity 2: Increase member awareness of Emergency Room alternative providers and when those alternatives are appropriate
Intervention: Program coordinators will outreach members accessing the Emergency Room for behavioral health and substance use diagnosis to coordinate care and engage in care management, if appropriate.

Additionally, Patient (Member) Analytics is a PHM tool designed to support providers in the delivery of timely, efficient, and evidence-based care to our members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. The Patient (Member) Analytics tool allows providers to view key data elements including Emergency Room Visits. Within the Patient (Member) Analytics tool, providers have easy access to check a member's eligibility, review their claims, access their patient list, and view comprehensive reports of care opportunities at member and population level. Claims-based patient histories from across the continuum of care including disease registries to support condition-specific member outreach are available in exportable formats to support chart records and reports.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Members with over utilization or potential over utilization of the Emergency Room
Emergency Department Diversion Program
Num: 1212
Dem: 77,268
Rate: 63.88%

Identify any barriers to implementing initiatives:
Barrier: Lack of member utilization of appropriate services post-discharge that leads to unplanned re-admissions.
Barrier: Knowledge deficit related to Emergency Room alternatives.

Identify strategy for continued improvement or overcoming identified barriers:
Getting the Right Care messaging is being utilized with all members via emails and newsletters.
Targeted outreach to members who are reporting overutilizing ED by case management team is being conducted.
Targeted outreach post ED discharge by case management team to assist with follow up appointments, ensuring mediations are picked up, SDOH barriers is being conducted.

HSAG Assessment:
NTC did not sufficiently address the CY 2022–2023 recommendations regarding the *Ambulatory Care—ED Visits—Total* measure indicator. **NTC**'s MY 2022 results for the *Ambulatory Care—ED Visits—Total* measure indicator continue to show higher utilization of the ED. HSAG recognizes **NTC**'s work to identify the factors contributing to higher ED utilization and recommends that **NTC** continue to implement the reported interventions to reduce ED visits.

Recommendations for Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. A "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management. HSAG recommended that **NTC** work with its providers to ensure diagnosis and treatment of members are complete and precise in order to improve readmission rates.

Response

Describe initiatives implemented based on recommendations:
A data analysis of the PCR population was done to further understand the diagnosis of these members. Findings showed behavioral health (BH) diagnosis were most prevalent in members being readmitted. To support our BH members who have had an inpatient stay, **NTC** created a position, BH CM / TOC (Transition of Care), to outreach members prior to discharge and follow up post.

Additionally, provider education on our PCR PIP was shared in our provider newsletter and during provider meetings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Members with the BH TOC staff support prior to and post discharge had a 99.17% success in not having an unexpected readmission (Q4 2022); the PCR rate from Q32022, 12.42%, was reduced to 11.56% in Q4 2022.
Identify any barriers to implementing initiatives: The first candidate for the BH/TOC fell through, so the intervention did not take place until September 2022. Second barrier – if staff exited the position or were out of the office.
Identify strategy for continued improvement or overcoming identified barriers: The open position was moved back to open and new candidates interviewed. BH/TOC position is maintained as a crucial piece of our case management team. Other team members are also now trained in the workflows of this position to assist, as needed, with an increased workload.
HSAG Assessment: **NTC** did not sufficiently address the CY 2022–2023 recommendations regarding the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator. **NTC**'s performance on the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator improved from MY 2021 to MY 2022. However, **NTC**'s MY 2022 result on this indicator remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **NTC**'s efforts to identify the members impacting performance on this indicator and work with providers to address the causes of readmissions. HSAG recommends that **NTC** continue these efforts to improve performance on this indicator.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table B-13—Compliance With Regulations—Trended Performance for NTC

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**	Year Three (2023–2024)**
Standard Number and Title	**NTC Results**		
Standard I—Enrollment and Disenrollment	100%	100%	
Standard II—Member Rights and Confidentiality	83%		100%
Standard III—Member Information	77%		100%
Standard IV—Emergency and Poststabilization Services	100%	100%	
Standard V—Adequate Capacity and Availability of Services	86%		100%
Standard VI—Coordination and Continuity of Care	100%		100%
Standard VII—Coverage and Authorization of Services	84%		84.2%
Standard VIII—Provider Selection and Program Integrity	94%	94%	
Standard IX—Subcontractual Relationships and Delegation	100%	75%	
Standard X—Practice Guidelines	100%	100%	
Standard XI—Health Information Systems	100%	100%	
Standard XII—Quality Assessment and Performance Improvement	100%	100%	
Standard XIII—Grievance and Appeal System	77%		100%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Strengths

NTC submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Five out of six standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the Member Rights and Confidentiality standard, indicating members are receiving timely and adequate access to information that can assist them in accessing care and services. **[Access]**

NTC achieved full compliance in the Member Information standard, indicating members are receiving information regarding their rights and protections. **[Access]**

NTC achieved full compliance in the Adequate Capacity and Availability of Services standard, demonstrating the MCE maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**

NTC achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for its care management program. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the Grievance and Appeal System standard, demonstrating the MCE had processes in place for handling member complaints, grievances, and appeals. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

NTC should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

For the Member Information standard, HSAG recommended that **NTC** make available a provider directory on the website in a machine-readable file and format that is useful to the member. **[Access]**

NTC received a score of 84.2 percent for the Coverage and Authorization of Services standard. **NTC** must revise its policies, procedure, and timeliness monitoring to align with the federal regulation that includes accurate time frames for making expedited authorization decisions and provide notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. Additionally, **NTC** must ensure policies and procedures include all provisions for extending the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if:

- The member or the *provider* requests an extension.
- The MCE justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

If the MCE extends the time frame for standard or expedited authorization decisions, it must:

- *Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires).*

- *Inform the member of the right to file a grievance if he or she disagrees with that decision.*
- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Furthermore, **NTC** must revise all applicable letters to clearly state that members may file an appeal orally or in writing. Additionally, **NTC** must revise its applicable NABD letter templates to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal. **[Timeliness** and **Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-14 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table B-14—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendations
HSAG found **NTC**'s policy, Non-Discrimination in Contracting Practices, included provisions for prohibiting provider discrimination that referenced 42 CFR §438.12(a)(1)–(2); 438.214(c). Additionally, **NTC** provided a Nondiscriminatory Credentialing and Recredentialing policy and procedure with state-specific attachments. However, after reviewing the policy and attachment, HSAG determined that the documentation did not mention Nebraska-specific details. To avoid confusion and ensure consistency with other states' documentation, HSAG recommended that **NTC** include the provisions prohibiting provider discrimination found in 42 CFR §438.12(a)(1)–(2); 438.214(c) by adding them to the Nebraska-specific attachment of the Nondiscrimination Credentialing and Recredentialing policy.
Response
Describe initiatives implemented based on recommendations: All Centene health plans will adopt and utilize corporate policies, implementing state specific requirements that may be more stringent via addendums or health plan specific policies. CC.Cred.04 Nondiscrim Cred and Recred policy is the corporate policy, provided via the 06/07/2022 submission of documentation, including the reference to 42 CFR §438.12 and NE.PRCN.05 is the health plan specific policy that was provided on the 06/07/2022 submission, including reference to 42 CFR §438.12(b). With the Corporate policy referencing the overall 42 CFR §438.12, and requirement that all health plans follow corporate policy, this recommendation can be concluded as referenced between the two existing policies.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: N/A
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.

Validation of Network Adequacy

Results

Network Capacity Analysis

The number of members enrolled with NTC was determined from the Medicaid enrollment data provided by DHHS. Table B-15 provides the number of eligible members in each population used to measure the adequacy of NTC's provider network. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYNs were limited to female members 15 years of age and older.

Table B-15—Population of Eligible Members for NTC

Member Population	Members
Children 18 Years and Younger	65,670
Females 15 Years and Older	47,246
All Members*	131,021

*"All Members" may not equal the sum of "Children 18 Years and Younger" and "Females 15 Years and Older" as the latter categories overlap and do not include adult males. In addition, "All Members" includes members whose age was not known.

Table B-16 displays NTC's statewide network capacity analysis results (i.e., the number of the number of providers and provider ratios) for all applicable provider categories alongside results for pediatric specialists in appropriate provider categories. Pediatric providers were identified by a combination of taxonomy codes and provider specialties in the MCO provider data.

Table B-16—Network Capacity Analysis Results for NTC by Provider Category*

Provider Category	Providers	Ratio**
PCPs	2,365	1:56
PCPs, Pediatric	1,926	1:35
High-Volume Specialists* **		
Cardiologists	340	1:386
Cardiologists, Pediatric	36	1:1,825
Neurologists	298	1:440
Neurologists, Pediatric	35	1:1,877
OB/GYNs	291	1:163

Provider Category	Providers	Ratio**
Oncologists/Hematologists	82	1:1,598
Oncologists/Hematologists, Pediatric	10	1:6,567
Orthopedics	320	1:410
Orthopedics, Pediatric	4	1:16,418
Pharmacies	415	1:316
Behavioral Health Inpatient and Residential Service Providers	19	1:6,896
Behavioral Health Outpatient Assessment and Treatment Providers	3,227	1:41
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	28	1:2,346
Hospitals	81	1:1,618

*Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
**In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older, and pediatric providers, where the member population was limited to members 18 years of age and younger.
***High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Geographic Access Analysis

Table B-17 displays the percentage of **NTC**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table B-17—Percentage of NTC Members with Required Access to Care by Provider Type, Urbanicity

		NTC
Provider Category	**Urbanicity**	**Percentage of Members With Required Access**
PCPs	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists	Statewide	99.9%

		NTC
Provider Category	**Urbanicity**	**Percentage of Members With Required Access**
Neurologists	Statewide	100.0%
OB/GYNs	Statewide	99.9%
Oncologists/Hematologists	Statewide	99.5%
Orthopedics	Statewide	100.0%
Pharmacies	Urban (90%)	96.0%
	Rural (70%)	90.3%
	Frontier (70%)	97.6%
Behavioral Health Inpatient and Residential Service Providers	Urban	100.0%
	Rural	100.0%
	Frontier	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	>99.9%
	Rural	>99.9%
	Frontier	97.8%
Hospitals	Statewide	96.1%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table B-18 displays the percentage of **NTC**'s pediatric members who have the access to care required by contract standards for all applicable provider categories and urbanicities.

Table B-18—Percentage of Pediatric NTC Members With Required Access to Care by Provider Category and Urbanicity*

Provider Category	Urbanicity	Percentage of Members With Required Access
PCPs, Pediatric	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists, Pediatric	Statewide	99.7%
Neurologists, Pediatric	Statewide	94.0%

Provider Category	Urbanicity	Percentage of Members With Required Access
Oncologists/Hematologists, Pediatric	Statewide	71.5%
Orthopedics, Pediatric	Statewide	86.2%
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	Urban	73.2%
	Rural	42.7%
	Frontier	4.6%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table B-19 and Table B-20 display the percentage of **NTC**'s members with the access to care required by contract standards for behavioral health categories by Behavioral Health Region.

Table B-19—Percentage of NTC Members With Required Access to Inpatient and Residential Service Providers by Behavioral Health Region

Behavioral Health Services	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%

Table B-20—Percentage of NTC Members With Required Access to Outpatient Behavioral Health Services by Population and Behavioral Health Region

Behavioral Health Services	Percentage of Members With Required Access	Percentage of Pediatric Members With Required Access
Behavioral Health Outpatient Assessment and Treatment Providers		
Region 1	100.0%	0.0%
Region 2	98.4%	0.0%
Region 3	100.0%	0.0%

Behavioral Health Services	Percentage of Members With Required Access	Percentage of Pediatric Members With Required Access
Region 4	>99.9%	45.5%
Region 5	100.0%	84.0%
Region 6	100.0%	99.1%

* Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region. The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table B-21 identifies the counties where the minimum geographic access standards were not met by NTC in a specific urbanicity or Behavioral Health Region for each applicable provider category, including pediatric specialists for appropriate categories. Results are presented separately for the general and pediatric populations as appropriate.

Table B-21—Counties Not Meeting Standards for NTC by Urbanicity and Behavioral Health Region

Provider Category	Counties Not Meeting Standard
PCPs	
Urban	Lincoln
PCPs, Pediatric	
Urban	Lincoln
High-Volume Specialists**	
Cardiologists	Cherry
OB/GYNs	Cherry
Oncologists/Hematologists	Cherry, Grant, Sheridan
High-Volume Specialists, Pediatric**	
Cardiologists, Pediatric	Brown, Cherry, Loup
Neurologists, Pediatric	Arthur, Blaine, Box Butte, Boyd, Brown, Chase, Cherry, Cheyenne, Custer, Dawes, Deuel, Dundy, Garden, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Red Willow, Rock, Scotts Bluff, Sheridan, Sioux, Thomas

Provider Category	Counties Not Meeting Standard
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thomas, Valley, Wayne, Webster, Wheeler
Orthopedics, Pediatric	Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Cedar, Chase, Cherry, Cheyenne, Custer, Dawes, Deuel, Dixon, Dundy, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Morrill, Perkins, Pierce, Red Willow, Rock, Scotts Bluff, Sheridan, Sioux, Stanton, Thomas, Wayne, Wheeler
Pharmacies	
Urban	Buffalo, Dodge, Gage, Lincoln, Scotts Bluff
Rural	Clay, Custer, Polk, Richardson
Frontier	Hooker, Thomas
Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Dundy, Hooker, Thomas
Region 2	Dundy, Hooker, Lincoln, Thomas
Region 4	Cherry
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Adams, Buffalo, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Butler, Cherry, Cheyenne, Clay, Colfax, Custer, Dawes, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Keith, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Polk, Red Willow, Richardson, Saline, Thayer, Valley, Webster, York
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler

Provider Category	Counties Not Meeting Standard
Region 1	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Region 2	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
Region 3	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
Region 4	Antelope, Boone, Boyd, Brown, Cherry, Colfax, Holt, Keya Paha, Madison, Nance, Platte, Rock
Region 5	Butler, Fillmore, Gage, Jefferson, Johnson, Nemaha, Pawnee, Polk, Richardson, Saline, Thayer, York
Region 6	Dodge
Hospitals* **	
Hospitals	Adams, Arthur, Banner, Blaine, Box Butte, Boyd, Buffalo, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Custer, Dawes, Dawson, Dixon, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Grant, Greeley, Harlan, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, McPherson, Nuckolls, Saunders, Sheridan, Sherman, Sioux, Thayer, Thomas, Valley, Wayne, Wheeler

*Rows are only shown if at least one county did not meet the standard.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.
***The standard for this provider category does not differ by urbanicity.

Strengths

NTC achieved compliance with eight of 12 network access standards by urbanicity, and two of six statewide standards. **NTC** also achieved compliance with 10 of 12 behavioral health access standards by Behavioral Health Region. **[Access]**

Among standards for which **NTC** did not achieve 100 percent compliance, it achieved at least 98 percent compliance with three of the remaining four network access standards by urbanicity and three of the remaining four statewide standards. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

None of **NTC**'s members had access to pediatric outpatient behavioral health specialists within the standard in Regions 1, 2, or 3, and only 45.5 percent of members had access in Region 4 and 84.0 percent in Region 5. Only members residing in Region 6 had access that approached the state standard for these providers (99.1 percent). For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, as contrasted with the

lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-22 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table B-22—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
NTC's greatest opportunity for improvement is to strengthen its network of pharmacies available to members in rural counties.
Response
Describe initiatives implemented based on recommendations: Our network of 715 pharmacies provide convenient access for members. This includes a clinically integrated network of 62 independent pharmacies providing members with enhanced pharmacy services (refill reconciliation, medications delivered to members free of charge in adherence packaging, monthly medication reviews by pharmacists and outreach to prescribers to close gaps in care) from local pharmacists they know, many of which are in rural settings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Members living in rural areas on average are 4.8 miles from the closest network pharmacy. The closest pharmacy is only 14 miles on average for members living in frontier areas.
Identify any barriers to implementing initiatives: Per Nebraska Medicaid contract requirements, only pharmacies that are enrolled with Nebraska Medicaid, as demonstrated on the NE Provider Roster file, are allowed to process claims for Nebraska Total Care Medicaid members. Nebraska Total Care is contracted with 96% of retail pharmacies on the NE Provider Roster file.
Identify strategy for continued improvement or overcoming identified barriers: Ongoing quarterly geo access network adequacy reviews and network team engagement with non-contractual rural pharmacies.
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
NTC could significantly improve access to pediatric specialists across all provider types and regions.
Response
Describe initiatives implemented based on recommendations: NTC has been working primarily with Children's of Omaha to expand in-person and telehealth pediatric specialist access and availability in rural areas. When appointment availability is routine, Children's includes the availability on their website and roster, and NTC will reflect within our directory. For many of the specialties, access is available through Telehealth only, so this will not be reflected in the directory.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Children's of Omaha has increased access via telehealth for many specialties, including the following: Allergy, Cardiology, Cardiothoracic Surgery, Chronic Pain, Developmental Pediatrics, Endocrinology, Eating Disorders, ENT, Gastroenterology, Genetics, Infectious Disease, Metabolic Management, Nephrology,

Recommendations
Ophthalmology, Orthopedics, Palliative Care, Physical Medicine & Rehabilitation, Psychology, Psychiatry, Rehabilitation Services, Rheumatology, Respiratory, Sleep Medicine, Sports Physical Therapy, Urology, and Weight & Wellness.
Identify any barriers to implementing initiatives: While access is improving, primarily via telehealth, access improvements will in most cases not be noted in NTC directory for the reasons outlined above.
Identify strategy for continued improvement or overcoming identified barriers: Continuing collaboration with Children's of Omaha and other pediatric specialty providers to enhance access.
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.
Response
Describe initiatives implemented based on recommendations: Typically, NTC findings are that providers are not available under given specialty within set time and distance standards. NTC uses both the state provider file and Quest Analytics to identify providers who are in network with any competitor.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NTC measures against the state provider file and shows the following overlap when measuring group level participation: 100% of Nebraska Hospitals, 100% of Nebraska Critical Access Hospital, 100% of Nebraska FQHCs, 98% of in-state PCP groups, 97% of in-state Behavioral Health groups, 99% of Women's Health provider groups, 100% of Hematology-Oncology provider groups, 99% of Cardiologist provider groups, 98% of Neurology provider groups, 99% of Orthopedic Surgeon provider groups.
Identify any barriers to implementing initiatives: Typically, NTC findings are that providers are not available under given specialty within set time and distance standards. NTC uses both the state provider file and Quest Analytics to identify providers who are in network with any competitor.
Identify strategy for continued improvement or overcoming identified barriers: Continuous monitoring of state provider file, Quest Analytics, work with Nebraska Healthcare, Rural Healthcare, Medical, and Hospital associations, and work to recruit new providers who are in the market, but do not accept Medicaid currently.
HSAG Assessment: NTC sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Plan All-Cause Readmissions*

UHCCP submitted the clinical PIP, *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*, focused on improving performance in the total observed 30-day readmission rate for the *HEDIS Plan All-Cause Readmissions* measure, for the CY 2023–2024 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission. **UHCCP** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table C-1 summarizes **UHCCP**'s PIP validation scores.

Table C-1—2023–2024 PIP Validation Results for UHCCP

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission	Initial Submission	90%	89%	*Partially Met*
	Resubmission	100%	100%	*Met*

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table C-2 presents baseline, Remeasurement 1, and Remeasurement 2 performance indicator data for **UHCCP**'s *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table C-2—Performance Indicator Results for UHCCP's *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 133 D: 1,131	11.76%	N: 149 D: 1,427	10.44%	N: 180 D: 2,215	8.13%	*Not Assessed*

N–Numerator, D–Denominator

For the baseline measurement period, **UHCCP** reported that 11.76 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. For the first remeasurement period, **UHCCP** reported that 10.44 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The decrease in the total observed readmission rate of 1.32 percentage points represented an improvement in indicator performance from baseline to Remeasurement 1; however, the improvement was not statistically significant ($p = 0.2905$).

For the second remeasurement period, **UHCCP** reported that 8.13 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 2 rate was an improvement (decrease) of 3.63 percentage points from the baseline rate. The decrease in readmission rates from baseline to Remeasurement 2 represented a statistically significant improvement ($p = 0.0006$) in indicator performance compared to initial indicator results.

Nonclinical PIP: *Improving the Member Experience with the Health Plan's Member Services*

UHCCP submitted the nonclinical PIP, *Improving the Member Experience with the Health Plan's Member Services*, focused on improving performance in the percentage of adult members who responded to Question 24 in the CAHPS Health Plan Survey 5.1H "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" with a response of "Usually" or "Always," for the CY 2023–2024 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission. **UHCCP** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table C-3 summarizes **UHCCP**'s PIP validation scores.

Table C-3—2023–2024 PIP Validation Results for UHCCP

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Improving the Member Experience with the Health Plan's Member Services	Initial Submission	75%	70%	*Partially Met*
	Resubmission	100%	100%	*Met*

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table C-4 presents baseline performance indicator data for **UHCCP**'s *Improving the Member Experience with the Health Plan's Member Services* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table C-4—Performance Indicator Results for UHCCP's *Improving the Member Experience with the Health Plan's Member Services* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
The percentage of adult members who responded to Question 24 in the CAHPS Health Plan Survey 5.1H "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" with a response of "Usually" or "Always."	N: 60	78.9%	N: NA	NA	*Not Assessed*
	D: 76		D: NA		

N–Numerator, D–Denominator
NA–Not Applicable

For the baseline measurement period, **UHCCP** reported that 78.9 percent of adult members who responded to CAHPS Survey Question 24 reported that the health plan's customer service "usually" or "always" provided needed information or help in the last six months.

Interventions

Clinical PIP: *Plan All-Cause Readmissions*

For the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP, **UHCCP** reported using data analyses, intervention evaluation results, and workgroup discussion to identify the following barriers and interventions to improve performance indicator outcomes.

Table C-5 displays the barriers and interventions as documented by the health plan for the PIP.

Table C-5—Interventions Implemented/Planned for the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP

Barriers	Interventions
Member medication noncompliance.	Targeted outreach to reconcile medications within 14 days of an acute inpatient discharge for members with a primary behavioral health or medical diagnosis.
Lack of member participation in care management services to support management of behavioral health and/or physical medical conditions.	Targeted outreach for members with a primary behavioral health or medical diagnosis prior to an acute inpatient stay to provide education on care management services and engage members in care management services.
Insufficient or inaccurate member contact information.	Actively seek out and update member contact information as part of targeted member outreach.

Nonclinical PIP: *Improving the Member Experience with the Health Plan's Member Services*

For the *Improving the Member Experience with the Health Plan's Member Services* PIP, **UHCCP** reported using data analyses, intervention evaluation results, and workgroup discussion to identify the following barriers and interventions to improve performance indicator outcomes.

Table C-6 displays the barriers and interventions as documented by the health plan for the PIP.

Table C-6—Interventions Implemented/Planned for the *Improving the Member Experience with the Health Plan's Member Services* PIP

Barriers	Interventions
• Member experience survey is voluntary for members; therefore, not all members respond. • Lack of member participation in the survey.	Members are provided a convenient opportunity to complete the survey by opting in to take a three-question United Experience Survey (UES) following their inbound call to Member Services to rate their experience.
A lower number of completed surveys provides supervisors with fewer opportunities to provide feedback and coach staff.	Team supervisors review inbound member calls to Member Services and provide feedback and coaching to staff for calls receiving a composite score of less than or equal to 92 percent on the UES.
The survey is voluntary, and the goal is to complete 10 surveys each business day; however, there is no guarantee how many member outreach calls will be needed to complete 10 surveys.	Members receive a follow-up call within one business day with a two-question survey and are asked if they received the information and/or help they needed with their most recent inbound call to Member Services.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **UHCCP** followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **UHCCP** reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs. **[Quality]**
- **UHCCP** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**
- **UHCCP** reported Remeasurement 2 results for the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP that demonstrated statistically significant improvement in the readmissions rate compared to baseline performance. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG did not identify any opportunities for improvement.

To support sustained improvement in the access to and timeliness of dental care for its members, HSAG offers the following recommendations for **UHCCP**:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**
- Identify strategies to continue and spread successful interventions to support sustained and further improvement in performance indicator outcomes over time. **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table C-7 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table C-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
Opportunity for Improvement: Although **UHCCP's** reported indicator results demonstrated an improvement in performance from baseline to Remeasurement 1, the improvement was not statistically significant.
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Response
Describe initiatives implemented based on recommendations: A review of the casual/barrier analyses is completed annually. The PIP workgroup verifies the identified barriers and opportunities for improvement and reviews any newly identified barriers. The PIP outreach staff were retrained on the interventions and corresponding documentation in July 2022, September 2022, October 2022, November 2022, December 2022, and January 2023. In addition, staff were retrained on appropriateness of completing Transitions of Care Assessment, medication reconciliation, and documenting member contact information in the member charting system during monthly PIP staff meetings as appropriate in 2022. Ongoing retraining/reeducation of staff occurs as appropriate. Staff assist members with any identified barriers, such as Social Determinants of Health (SDoH) needs and make referrals for ongoing case management as needed. All member call scripts are reviewed on an ongoing basis and updated as appropriate/when needed.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HEDIS PCR rate changed from Baseline year of 11.76% to Remeasurement Year 1 (MY2021) to 10.44%. HEDIS PCR rate continued to trend downward in Remeasurement Year 2 (MY2022) with a final audited rate of 8.39%, demonstrating a statistically significant change from baseline.
Identify any barriers to implementing initiatives: Ongoing quarterly data analysis continues to indicate stronger efforts are needed to reach members within 30 days of discharge in attempts to locate a valid phone number to successfully outreach member, however, lack of accurate/current contact information remains a barrier to reaching these members. Successful inpatient outreaches continue to be difficult to reach members due to medical testing, inpatient routine care and inpatient behavioral health units/facilities either limiting or prohibiting member interaction.
Identify strategy for continued improvement or overcoming identified barriers: The Health Plan will continue with the three identified interventions. The PIP outreach staff continue to attempt to engage with facility discharge planners to help identify and address any member barriers prior to discharge.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
Response
Describe initiatives implemented based on recommendations: The Health Plan utilizes a key driver diagram annual to determine barriers and process gaps. The Health Plan held retraining of the PIP case managers and reviewed all member call scripts. The PIP outreach staff were retrained on the interventions and corresponding documentation in July 2022, September 2022, October 2022, November 2022, December 2022, and January 2023. In addition, staff were retrained on appropriateness of completing Transitions of Care Assessment, medication reconciliation, and documenting member contact information in the member charting system during monthly PIP staff meetings as appropriate in 2022. Ongoing

retraining/reeducation of staff occurs as appropriate. All Standard of Practice (SOP) are kept up to date to include appropriate call scripts and documentation requirements.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Ongoing review of documentation supports retraining of PIP staff and member call scripts have been successful.

Identify any barriers to implementing initiatives:
High-volume of PIP staff transitioning on and off the PIP team has been a barrier with training/retraining.

Identify strategy for continued improvement or overcoming identified barriers:
The Health Plan will conduct staff training ongoing as needed.
Ongoing review of documentation is completed on a weekly basis on a random selection of records for each PIP staff. Documentation is held to the outlined process the staff have been trained on which can be found in corresponding Standard of Practice (SOPs). Reeducation of staff is completed at monthly meetings as appropriate or sooner if necessary.

HSAG Assessment: **UHCCP** sufficiently addressed the CY 2022–2023 recommendations.

Recommendations

Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Response

Describe initiatives implemented based on recommendations:
The health plan completes quarterly and annual evaluations of the data to measure the effectiveness of each intervention. The health plan PIP team targeted outreaches to members in three interventions.

1. Case Managers will outreach to members with a primary behavioral health or medical diagnosis, after an acute inpatient stay to reconcile medications within 14 calendar days of discharge.
2. Case Managers will outreach to members with a primary behavioral health or medical diagnosis prior to discharge from an acute inpatient stay to educate and engage member in care management services.
3. Case Managers will outreach members with a primary behavioral health or medical diagnosis after an acute inpatient stay within 30 days of discharge and attempt to locate a valid phone number to successfully reach member and update member contact information.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
The Health Plan decided to continue with interventions one through three.
In 2022, intervention number one demonstrated 2,290 unique members were successfully outreached and completed medication reconciliation and transition of care assessment within 14 calendar days of discharge.

This was an increase from MY2021 unique members successfully outreached of 1,733. Intervention number two demonstrated that 363 members were successfully outreached prior to discharge from an acute inpatient stay and members were educated on their available care management benefit. This was a decrease from MY2021 unique members successfully outreached Prior to discharge of 731. Intervention number three demonstrated that 132 unique members were successfully outreached post discharge that had previously been unable to reach due to invalid contact information; presenting an opportunity to assist members that were previously unable to reach. This was an increase from MY2021 unique members successfully outreached post discharge that had previously been unable to reach due to valid contact information of 50.

Identify any barriers to implementing initiatives:
Ongoing barriers identified:

a. Difficulty in obtaining and maintaining valid contact information for members.

b. Inpatient telephonic outreaches are difficult as members maybe unavailable due to medical testing or other medical services such as Physical Therapy, Speech Therapy or Occupational Therapy. c. Inpatient behavioral health units/facilities either limiting or prohibiting member phone interactions.
Identify strategy for continued improvement or overcoming identified barriers: The Health Plan PIP workgroup continues to perform Plan Do Study Act (PDSA) cycles to re-evaluate the effectiveness of the identified interventions. The Health Plan continues to work to develop relationships with Hospital/facilities discharge planning teams, review all data sources for current member telephonic contact information and perform face to face visits with members if appropriate. Optum Behavioral Health (OBH) has worked closely with CHI/Lasting Hope to develop a working relationship to assist members with discharge planning. OBH now has two Behavioral Health Advocates (BHA) that visit Lasting Hope one day a week and take part in discharge planning and work with the CHI transition coordinator. Also, an all-Managed Care Organization (MCO) meeting with DHHS Medical Services Director and the Nebraska Hospital Association (NHA) was held on 9/8/2023 to discuss discharge barriers. NHA will set up meetings with their Transitions of Care and/or Care Managers team to discuss resources offered by the MCO's and barriers to seeing members in the hospital. NHA has also identified a staff member for MCO touchpoint for redeterminations.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Measures

Results for Information Systems Standards Review

The table below provides a summary of **UHCCP**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix E* of this report.

Table C-8—Summary of Compliance With IS Standards for UHCCP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed and steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	The LO determined that **UHCCP** was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that **UHCCP** only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCEs continually assess data completeness and take steps to improve performance. • The MCEs effectively monitor the quality and accuracy of electronic submissions. • The MCEs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **UHCCP** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **UHCCP** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **UHCCP** reviewed all provider data received from delegated entities.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 4.0—MRR Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for ECDS reporting met reporting requirements. • NCQA validated data resulting from the DAV program met reporting requirements.	**UHCCP** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in nonstandard form that required PSV.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 6.0 for data pre-production processing. File consolidation and data extractions were performed by **UHCCP**'s staff members. Data were verified for accuracy at each data merge point.
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**UHCCP** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA-certified measure vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **UHCCP**. According to the DHHS's required data collection methodology, the rates displayed in Table C-10 reflect all final reported rates in **UHCCP**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **UHCCP** may have received an "NA" status for an indicator due to a small denominator within the measure but still have received an "R" designation for the total population.

Table C-9—HEDIS Audit Results for UHCCP

Audit Finding	Description	Audit Result
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	***R***
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	***NA******
The MCO did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	***NB****
The MCO chose not to report the measure.	Not Reported	***NR***
The MCO was not required to report the measure.	Not Required	***NQ****
The rate calculated by the MCO was materially biased.	Biased Rate	***BR***
The MCO chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).	Unaudited	***UN***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table C-10—UHCCP's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
Effectiveness of Care: Prevention and Screening				
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	75.43%	71.53%	68.37% ★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	69.59%	66.42%	66.67% ★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	65.69%	65.94%	66.91% ★★	R
CIS: Childhood Immunization Status—Combination 3	78.59%	72.51%	77.37% ★★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
CIS: Childhood Immunization Status—Combination 7	—	63.99%	69.10% ★★★★★	R
CIS: Childhood Immunization Status—Combination 10	54.74%	49.39%	53.77% ★★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, toxoids and acellular pertussis [Tdap])	82.24%	77.37%	82.00% ★★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	—	34.55%	37.47% ★★★	R
LSC: Lead Screening in Children	73.97%	70.32%	73.48% ★★★★	R
BCS: Breast Cancer Screening	63.77%	64.83%	62.86% ★★★★	R
CCS: Cervical Cancer Screening	60.83%	57.42%	60.58% ★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20	29.01%	28.35%	27.04% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24	39.96%	39.71%	38.59% ★	R
CHL: Chlamydia Screening in Women—Total	32.71%	32.69%	31.90% ★	R
Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	72.77%	71.20%	69.34% ★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	59.87%	60.64%	63.66% ★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65+	NA	NA	NA	R
CWP: Appropriate Testing for Pharyngitis—Total	70.77%	68.10%	67.52% ★★	R
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	26.12%	28.83%	28.57% ★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	67.07%	73.35%	72.62% ★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	84.15%	86.53%	86.43% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
AMR: Asthma Medication Ratio—Ages 5 to 11	79.72%	78.21%	74.43% ★★	R
AMR: Asthma Medication Ratio—Ages 12 to 18	73.62%	71.43%	74.95% ★★★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	69.11%	70.88%	68.01% ★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	68.64%	64.79%	64.32% ★★★	R
AMR: Asthma Medication Ratio—Total	74.05%	72.59%	70.97% ★★★★	R
Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure	68.37%	71.53%	76.40% ★★★★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	80.70%	76.92% ★★	R
Effectiveness of Care: Diabetes				
HBD: Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Control (<8.0%)	59.12%	60.10%	60.10% ★★★★	R
*HBD: HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)**	29.68%	31.14%	29.44% ★★★★★	R
BPD: Blood Pressure Control for Patients With Diabetes	71.78%	76.89%	76.16% ★★★★★	R
EED: Eye Exam for Patients With Diabetes	69.34%	65.94%	65.69% ★★★★★	R
Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	63.93%	66.16%	64.46% ★★★	R
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	48.67%	52.98%	47.48% ★★★	R
ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	45.64%	39.15%	48.05% ★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	55.30%	47.85%	55.04% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	56.88%	57.83%	53.06% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	78.90%	80.58%	76.12% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	44.43%	41.14%	38.88% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	66.41%	61.84%	60.96% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65+	NA	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	49.31%	45.98%	42.74% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	71.24%	67.21%	65.04% ★★★	R
FUM: Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total	45.40%	43.78%	37.42% ★★	R
FUM: Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	66.00%	64.21%	59.43% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)—7-Day Follow-Up—Total	13.08%	21.78%	23.27% ★★	R
FUI: Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	30.00%	42.33%	43.54% ★★	R
FUA: Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total	—	—	31.07% NC	R
FUA: Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	—	—	48.22% NC	R
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.33%	82.81%	82.26% ★★★	R
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	68.67%	75.21%	77.41% ★★★★★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	73.53%	75.68%	80.56% ★★★	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	81.13%	73.98%	75.58% ★★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
Effectiveness of Care: Overuse/Appropriateness				
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.51%	0.43%	0.46% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	88.28%	90.33%	90.71% ★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64	78.08%	80.56%	80.97% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65+	67.50%	NA	65.79% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Total	86.81%	88.53%	88.58% ★★	R
LBP: Use of Imaging Studies for Low Back Pain—Total	—	—	73.27% NC	R
*HDO: Use of Opioids at High Dosage**	7.23%	5.19%	4.15% ★★★	R
Access/Availability of Care				
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 13 to 17	—	—	34.09% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 13 to 17	—	—	12.50% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 18 to 64	—	—	36.68% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 18 to 64	—	—	11.14% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Ages 65+	—	—	44.27% NC	R
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Ages 65+	—	—	5.34% NC	R
IET: Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total	—	—	36.70% NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
IET: Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total	—	—	11.05% NC	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.05%	87.59%	86.62% ★★★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	78.10%	85.89%	83.45% ★★★★	R
Utilization[2]				
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.89%	63.03%	65.93% ★★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	70.35%	68.60%	66.66% ★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total^**	444.84	549.48	569.46 ★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^*	3,917.52	4,269.6	4,183.68 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total^*	72.48	70.68	63.22 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total	5.22	5.55	5.36 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total^*	52.56	36.96	31.07 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total	2.36	2.38	2.43 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total^*	13.56	16.44	14.63 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total	10.22	9.82	9.23 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate[1]	MY 2022 Audit Designation
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total^*	28.56	30.36	27.84 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total	5.89	5.72	5.51 NC	R
Risk Adjusted Utilization				
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	8.34%	11.41%	8.39% NC	R
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.16%	11.40%	10.92% NC	R
*PCR: Plan All-Cause Readmissions—Observed to Expected (O/E) Ratio—Total**	0.75	1.00	0.77 ★★★★★	R
Measures Collected Using Electronic Clinical Data Systems				
BCS-E: Breast Cancer Screening	34.88%	31.81%	62.67% NC	R

[1] Due to changes in percentile rankings represented in star ratings between MY 2021 and MY 2022, star ratings are displayed for MY 2022 only.
[2] In the Utilization domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for informational purposes only.
* For this indicator, a lower rate indicates better performance.
^ For this indicator, the rate is reported per 1,000 member months rather than a percentage.
NA indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2022 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table C-11—UHCCP's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
Adult Core Measures			
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	51.75%	43.22%	46.94%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 18 to 64**	—	4.99%	4.44%

CMS Core Set Measures	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer—Ages 65+**	—	6.28%	3.69%
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 18 to 64[1]	—	—	—
CDF-AD: Screening for Depression and Follow-Up Plan—Ages 65+[1]	—	—	—
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 18 to 64 Years**	—	24.63%	22.34%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Age 65 Years and Older**	—	21.97%	19.73%
Child Core Measures			
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 1 Year	—	26.42%	28.69%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 2 Years	—	33.70%	37.98%
DEV-CH: Developmental Screening in the First Three Years of Life—Children Turned 3 Years	—	32.09%	31.89%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	30.50%	32.94%
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17[1]	—	—	—
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Most or moderately effective contraception (MMEC)—within 3 days of delivery	—	—	1.91%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—MMEC—within 90 days of delivery	—	—	50.24%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—Long-acting reversible method of contraception (LARC)—within 3 days of delivery	—	—	0.96%
CCP-CH: Contraceptive Care—Postpartum Women Ages 15 to 20—LARC—within 90 days of delivery	—	—	23.92%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—MMEC	—	—	26.68%
CCW-CH: Contraceptive Care—All Women Ages 15 to 20—LARC	—	—	4.29%

[1] The CMS Adult and Child Core Set measures *CDF-AD* and *CDF-CH* were purposely excluded from the template DHHS supplied to the MCO for Core Measures reporting. The MCO did not report on these measures for the MY 2022 period.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year(s).

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*; *Immunizations for Adolescents—Combination 1* and *Combination 2*; *Lead Screening in Children*; *Breast Cancer Screening*; and *Cervical Cancer Screening* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. The *Immunizations for Adolescents—Combination 1* and *Combination 2* rates demonstrate that adolescents were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. The *Lead Screening in Children* rate demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they maintained limited exposure to lead. The *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 years were receiving screening for one of the most common causes of cancer death in the United States. Lastly, the *Breast Cancer Screening* rate demonstrates that women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Respiratory Conditions Domain

The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*, and *Asthma Medication Ratio—Ages 12 to 18, Ages 19 to 50, Ages 51 to 64,* and *Total* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* rate demonstrates that **UHCCP** providers were conducting spirometry testing to diagnose COPD, as recommended by the Global Initiative for Chronic Obstructive Lung Disease. [C-1] The *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* rates demonstrate that **UHCCP** providers were appropriately prescribing medication to help members control their COPD. Lastly, the *Asthma Medication Ratio* rates demonstrate that **UHCCP** providers effectively managed this treatable condition for members with persistent asthma. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 90th percentile benchmark for

[C-1] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease."

this measure. The rate for this measure demonstrates that **UHCCP** providers helped members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality and Timeliness]**

Effectiveness of Care: Diabetes Domain

The *HbA1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)*, *Blood Pressure Control for Patients With Diabetes*, and *Eye Exam for Patients With Diabetes* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 75th percentile benchmark for these measure indicators. The *HbA1c Control for Patients With Diabetes* rates demonstrate that **UHCCP** providers helped members effectively control their blood glucose levels, reducing the risk of complications. The *Blood Pressure Control for Patients With Diabetes* rate demonstrates that **UHCCP** providers helped adult members with diabetes adequately control their blood pressure. Lastly, the *Eye Exam for Patients With Diabetes* rate demonstrates that **UHCCP** providers ensured that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

For the following measure indicators, **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* **[Quality]**
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase* **[Quality, Timeliness, and Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total) and 30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64, and Total)* **[Quality, Timeliness, and Access]**
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**
- *Diabetes Monitoring for People With Diabetes and Schizophrenia* **[Quality]**
- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* **[Quality]**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **[Quality and Access]**

The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* rates demonstrate that **UHCCP** providers were effectively treating adult members diagnosed with major depression by prescribing antidepressant medication and helping them remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**

The *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* rates demonstrate that **UHCCP** providers ensured that children prescribed ADHD medication participated in timely initial and continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that **UHCCP** providers ensured that members hospitalized for mental illness received adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* rate demonstrates that **UHCCP** providers effectively managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes and cardiovascular disease. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, *Diabetes Monitoring for People With Diabetes and Schizophrenia*, and *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* rates demonstrate that **UHCCP** providers ensured that adult members on antipsychotics were properly screened and monitored to promote positive health outcomes for this population. **[Quality, Timeliness, and Access]**

Lastly, the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rate demonstrates that **UHCCP** providers ensured that members with schizophrenia or schizoaffective disorder adhered to their treatment plan and continued to use prescribed antipsychotic medications. **[Quality and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 65+* and *Use of Opioids at High Dosage* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The *Appropriate Treatment for Upper Respiratory Infection—Ages 65+* rate demonstrates that, for older members, **UHCCP** providers effectively managed the dispensing of antibiotic medication to treat URI. The *Use of Opioids at High Dosage* rate demonstrates that **UHCCP** providers prevented or minimized the prescribing of opioids at a dosage of ≥ 90 mg morphine equivalent dose. **[Quality]**

Access/Availability of Care Domain

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for these measure indicators. The rates for these measure indicators demonstrate that **UHCCP** providers ensured that members received timely and adequate prenatal and postpartum care, in alignment with guidance provided by the AAP and the ACOG. **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* rate shows that **UHCCP** providers ensured that children were seen by a PCP within the first 15 months of life to assess and influence members' early development. **[Quality and Access]**

The *Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total* measure indicator was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 50th percentile benchmark for this measure indicator. The *Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total* rate demonstrates that **UHCCP** providers ensured members received appropriate primary care to reduce preventable visits to the ED.

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 90th percentile benchmark. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. The rate on this measure indicator demonstrates that **UHCCP** providers had the appropriate processes in place to effectively coordinate care and provide support for members post-discharge. **[Quality]**

Measures Collected Using Electronic Clinical Data Systems Domain

HSAG did not identify any strengths when conducting the PMV for **UHCCP** within the *Measures Collected Using ECDS* domain.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. HSAG recommends that **UHCCP** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, HSAG recommends that **UHCCP** providers follow up annually with sexually active members through various modes of communication to ensure members return for yearly screening. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. The rate of this measure indicator suggests that child and adolescent members did not receive proper testing to merit antibiotic treatment for pharyngitis HSAG recommends that **UHCCP** work with providers to determine whether children and adolescents are properly tested to prevent the unnecessary use of antibiotics. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Effectiveness of Care: Cardiovascular Conditions* domain.

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Effectiveness of Care: Diabetes* domain.

Effectiveness of Care: Behavioral Health Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Effectiveness of Care: Behavioral Health* domain.

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. The rate for this measure indicator suggests that a diagnosis of URI resulted in an antibiotic dispensing event for child and adolescent members. HSAG recommends that **UHCCP** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommends that **UHCCP** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Access/Availability of Care* domain.

Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Utilization* domain.

Risk Adjusted Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Risk Adjusted Utilization* domain.

Measures Collected Using Electronic Clinical Data Systems Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the *Measures Collected Using ECDS* domain.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table C-12—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for Prevention and Screening Domain
• The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator was a weakness for **UHCCP**. For this measure indicator, **UHCCP**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. According to NCQA (as cited by the American Heart Association), child obesity has more than doubled over the last three decades and tripled in adolescents. HSAG recommended that DHHS work with **UHCCP** and its providers to strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. If the rate in children and adolescents receiving these services is identified to be related to the continuation of the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services. • The *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators were also a weakness for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic. HSAG continued to recommend that **UHCCP** providers follow up annually with sexually active members through any type of communication such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuing COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for ensuring ongoing access to these important services.
Response
Describe initiatives implemented based on recommendations: • WCC - All Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure. Member adherence reports are included in the Patient Care Opportunity Reports (PCORs) that are made available to providers monthly.

- Chlamydia Screening - The health plan partnered in a pilot project around Chlamydia screening and treatment with a FQHC located in North Omaha. The pilot included promoting screening services via a care message text and postcard to applicable UHC members. UHC provided funding to support a dedicated care coordinator for testing and on-site pharmacologic treatment as well as to promote educational campaigns for youth.

All Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure.
Member adherence reports are included in the Patient Care Opportunity Reports (PCORs) that are made available to providers monthly.
The UnitedHealthcare Member rewards program offers a $25 incentive to members to schedule and attend appointments to complete Chlamydia screenings.
We also use Our OmniChannel with mPulse program. This focuses on Chlamydia gap closure by outreaching to members based on their communication preference. The 3 methods of outreach include text, IVR and email.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- WCC – In 2022, the health plan noted continued downward trending for total WCC-BMI. Year over year rates demonstrate a decrease of 3.16% for all ages.
- Chlamydia Screening - In 2022, the health plan noted rates continue to trend downward in chlamydia screening for women ages 16-24. Year over year rates demonstrate a decrease of 1.31% for women ages 16-20 years of age, a decrease of 1.12% for women ages 21-24 years of age and a decrease of 0.79% for ages 16-24 years of age.

Identify any barriers to implementing initiatives:

- WCC – Barriers included incomplete claims submission requiring manual medical record review of documentation.
- Chlamydia Screening - Barriers encountered have been associated with access to testing, misinformation particularly in teenagers, and stigma associated with STIs.

Identify strategy for continued improvement or overcoming identified barriers:

- WCC – The health plan has recognized this as a significant opportunity for its child and adolescent population. These measures have been incorporated into all of our value based and incentive-based quality programs with our providers and our ACO partners. We partnered specifically with Nebraska's largest Children's hospital to address these measures and to offer additional services through consultation in their dedicated Weight and Wellness Specialty care clinic late in 2021, which resulted in that hospital improving overall performance and meeting two of three goals for the state of NE QPP program; they now include this metric in their value based ACO contract as well. Currently we have a rural provider in Crete Nebraska doing a pilot around physician directed weight loss and activity/nutrition counseling that includes these metrics as end outcomes. During our pilot with Childrens, we have also discovered that differing use of EMR data significant impacts some of our providers who may be capturing this data in a progress note, but do not have it in a discreet field that can be easily translated into a report. Our ACO teams have used Practice Assist to help providers to get credit for addressing WWC measures even when limited by IT constraints. We also recognized our tribal population as an opportunity area and are currently in a program with Nebraska Urban Indian to improve WWC screening as part of the routine Well Child Check and to educate the entire family unit on healthy living and preventative care in their lifestyles. Most recently we are working with the College of Public Health Center for Reducing Health Disparities to design a project utilizing an individualized interactive weight loss application in tandem with local area health ambassadors in North Omaha communities to support community wide weight and wellness activities targeted to BIPOC populations.

In quarter 3 of 2023, the health plan will present provider education on EPSDT and will speak to appropriate documentation for WCC-BMI. The health plan will continue to provide updated Path Guides to reference HEDIS measure guidelines for gap closure to providers. Health plan quality staff to review PCORs to assess for gaps in care and provide ongoing education.
Guidance for WCC-BMI will be included in a quarter 4, 2023 provider bulletin.

- Chlamydia Screening - The health plan has continued an incentive pathway for local health departments across the state and all FQHCs to focus on women's reproductive health and preventative screening for STIs throughout 2022 and year to date in 2023.

The Health Plan has incorporated the Chlamydia Screening metric into our health equity primary care physician incentive contracts in which providers are incentivized to target disparate care and gaps in care for populations needing Chlamydia Screening. The Health Plan also focused on high risk populations located in North Omaha by partnering with a nurse run clinic to offer free screening and education for members of the three zip codes that we have been identified with the highest opportunity for STI screening. During the first six months of 2022, 313 individuals were screened for STI and 110 were treated for either GC/Chlamydia, a treatment rate of 35% which is three times higher than a recent national publication in the Journal of Infection and Public We have also worked extensively with creating a network of trusted advisors in community roles to speak to various preventative health care needs. The Health Plan will work with these Trusted Advisors, particularly those who appeal to the teen population, to help improve the optics of testing and promote healthy sexual activity. The Health Plan will do a member outreach campaign to our members in the population.
In Quarter 4 of 2022, the Health Plan provided a virtual Provider training on Women's Health, which includes Chlamydia screening.

HSAG Assessment:
UHCCP did not sufficiently address the CY 2022–2023 recommendations regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. **UHCCP**'s performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator declined from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **UHCCP**'s work with providers to identify and close care gaps that impact performance on this indicator and recommends that **UHCCP** continue these efforts.
UHCCP did not sufficiently address the CY 2022–2023 recommendations regarding the *Chlamydia Screening in Women—Ages 16 to 20*, *Ages 21 to 24*, and *Total* measure indicators. **UHCCP**'s performance on these measure indicators declined from MY 2021 to MY 2022. HSAG recognizes **UHCCP**'s work with providers to identify and address care gaps and use of incentives to encourage sexually active women members to receive chlamydia screening. HSAG recommends that **UHCCP** continue these efforts.

Recommendations for Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **UHCCP**. For this measure indicator, **UHCCP**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG continued to recommend that **UHCCP** conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria. In addition, HSAG continues to recommend that providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.

Response
Describe initiatives implemented based on recommendations: The health plan meets monthly with our ACO's to review data and identified a possible contributing factor that many members are being seen in the ER where time constraints may lead to overdiagnosis. All Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2022, the health plan noted a 0.38% slight decrease in appropriate treatment for upper respiratory infection for members ages 3 months to 17 years of age from 2021.
Identify any barriers to implementing initiatives: Poor provider attendance for training sessions.
Identify strategy for continued improvement or overcoming identified barriers: Provider training on URI was completed November 2022 by our CMO titled "Respiratory Health". Additional provider training is scheduled for 10/15/2023 on URI to be presented by our CMO. Also, guidance for upper respiratory treatment will be included in a quarter 4, 2023 provider bulletin.
HSAG Assessment: **UHCCP** did not sufficiently address the CY 2022–2023 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator. **UHCCP**'s performance on the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was consistent from MY 2021 to MY 2022 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **UHCCP**'s efforts to identify and address the circumstances resulting in the potential overprescribing of antibiotics and recommends that **UHCCP** continue these efforts.
Recommendations for Access/Availability of Care Domain
The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17*, *Initiation of AOD Treatment—Total—Ages 18 and Older*, and *Initiation of AOD Treatment—Total—Total* measure indicators were a weakness for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care. HSAG recommended that **UHCCP** work with its providers to ensure they are reaching members with identified SUD and to engage in follow-up treatment. **UHCCP** might consider working with providers to illustrate the time sensitivity of the measure requirements and ask providers about their strategies for engagement in treatment.
Response
Describe initiatives implemented based on recommendations: In March 2022, an IET email blast was distributed to educated network behavioral health practitioners and included the IET guidelines. This email blast was sent to 2,319 Nebraska behavioral health providers. In addition, a 3-Part On-Demand Series HEDIS® training has been provided with a specific segment on SUD measures was made available to primary care providers that reviewed best practices for the integration of behavioral care into a primary care setting to improve outcomes. Providers can earn free CEUs to improve awareness of the need for members to be referred to SUD treatment. Ongoing provider education on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and providing resources around appropriate referrals to care via the provider website. A PCP toolkit is also available to educate/remind providers of SUD resources and best practice guidelines.

Health services staff outreach each member post discharge to complete a transition of care assessment, medication reconciliation, and assistance with any barriers the member be experiencing. Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure. Member adherence reports are included in the PCORs that made available to providers on a monthly basis.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
In 2022, the health plan noted varied results as they relate to the initiation and engagement of alcohol and other drug abuse or dependence treatment measure. There was a year over year increase of 3.20% for the category of initiation of alcohol and other drug treatment total for ages 13-17 years of age. There was also a year over year improvement noted in general for the 13-17 years of age group.
There was a year over year decrease of 2.04% for the category of initiation of alcohol and other drug treatment to ages 18 and older. There was a year over year decrease of 1.72% for the category of initiation of alcohol and other drug treatment for total/all ages.

Identify any barriers to implementing initiatives:
Barriers include limited facility data exchange for timely discharge notification and difficulty in getting members to engage. Limited availability of providers and appointment times for follow up appointments post discharge with a short turn-around time to complete follow up visits.

Substance abuse confidentiality regulations are one barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent is challenging due to lack of accurate contact information on members, members not responding to outreach, and there is significant difficulty with health plan ability to obtain written consent in a timely manner to impact the short window of time on SUD follow-up treatment needed to improve the specific HEDIS® measure. Also, while many providers are making referrals and setting up subsequent SUD treatment for members, some members lack motivation for treatment and may be in denial they have a substance use issue. Therefore, they are not following through with treatment.

Identify strategy for continued improvement or overcoming identified barriers:
In February 2023, two email blasts were sent to 2251 BH Providers for the IET measure; one email provided education on "Treatment for Individuals with Substance Use Disorder" and the second one provided education on "MOUD (medications for opioid use disorder) and MAUD (medications for alcohol use disorder) help control withdrawal symptoms and cravings. Without these medications, 90% of individuals with Opioid Use Disorder (OUD) relapse within one year." An IET behavioral health incentive contract is in development in which providers are incentivized to target disparate care and gaps in care for populations that fall into the IET metric, development is set for completion in quarter one of 2024. In addition, the 3-Part On-Demand Video Series on Behavioral Health Identification, Treatment and Referral in Primary Care provided by Optum Health Education has been updated for 2023 and is currently available to providers. Providers may earn up to three credits for completing all three on-demand webcasts; Part One: Depression and Follow-up After Higher Levels of Care (expires June 8, 2024), Part Two: Substance Use Disorders in Primary Care (expires November 1, 2024), and Part Three: Behavioral Health Treatment for Children and Adolescents (expires February 14, 2025). The **UHCCP**-NE Chief Medical Officer is also currently meeting with the medical director for the Antimicrobial Stewardship And Assessment (ASAP) team from DHHS to develop a provider communication regarding appropriate use of antibiotics for URI's. A report of prescribers was developed which included diagnosis and antibiotics, as well as dose and duration. This collaboration is ongoing.

HSAG Assessment:
The technical specifications for the *Initiation and Engagement of SUD Treatment* measure underwent major changes in MY 2022. Therefore, MY 2022 results for this measure are not comparable to MY 2021 results.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table C-13—Compliance With Regulations—Trended Performance for UHCCP

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**	Year Three (2023–2024)**
Standard Number and Title	**UHCCP Results**		
Standard I—Enrollment and Disenrollment	100%	100%	
Standard II—Member Rights and Confidentiality	83%		83.3%
Standard III—Member Information	77%		77.3%
Standard IV—Emergency and Poststabilization Services	100%	100%	
Standard V—Adequate Capacity and Availability of Services	86%		100%
Standard VI—Coordination and Continuity of Care	100%		100%
Standard VII—Coverage and Authorization of Services	84%		100%
Standard VIII—Provider Selection and Program Integrity	94%	94%	
Standard IX—Subcontractual Relationships and Delegation	100%	75%	
Standard X—Practice Guidelines	100%	100%	
Standard XI—Health Information Systems	100%	100%	
Standard XII—Quality Assessment and Performance Improvement	100%	100%	
Standard XIII—Grievance and Appeal System	77%		96.2%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Strengths

UHCCP submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Three out of six standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

UHCCP achieved full compliance in the Adequate Capacity and Availability of Services standard, demonstrating the MCE maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**

UHCCP achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for its care management program. **[Quality, Timeliness, and Access]**

UHCCP achieved full compliance in the Coverage and Authorization of Services standard, demonstrating the MCE had a thorough and comprehensive approach for review, authorization, and denial of services. **[Timeliness and Access]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

UHCCP should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

UHCCP received a score of 83.3 percent for the Member Rights and Confidentiality standard. **UHCCP** must ensure policies and procedures, and other applicable documents, including the member handbook and provider manual, include the provision for a member to request and receive a copy of his or her medical records and request that they be amended or corrected. **[Access]**

UHCCP received a score of 77.3 percent for the Member Information standard. HSAG recommended that **UHCCP** update the member handbook to include the language "rescheduling an appointment, rather than being a no-show," so that the member is informed that they also have an option to reschedule. Additionally, HSAG recommended that in order to thoroughly inform the member, the member handbook should also include requirements about where a member can seek assistance in executing an advance directive, and to whom copies should be given. The member handbook lacked information about to whom advance directive copies should be given. Also, for the Member Information standard, **UHCCP** must update policies, the member handbook, and other applicable documents/notices informing members that **UHCCP** will make interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language, and written translation is available in prevalent languages, and how to access these services. This includes oral interpretation and use of auxiliary aides such as Teletypewriters/Telecommunications Device for the Deaf (TTY/TDY) and ASL. Additionally, the MCE must notify members that auxiliary aides and services are available upon request and at no cost for members with disabilities, and how to access them. In addition, the MCE must follow policies and procedures to give members written notice of any significant change in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change. Moreover, the MCE must update the member handbook informing members of the following:

- The definition of "State fair hearing."

- Information on how to report suspected fraud or abuse, which must include MLTC's toll-free number.
- Make information available to members, upon, request, to include the structure and operation of the MCE. **[Access]**

UHCCP received a score of 96.2 percent for the Grievance and Appeal System standard. HSAG recommended that **UHCCP** review the grievance and appeal processes within the United Healthcare Appeals Grievances Introduction PowerPoint to differentiate the time frame requirements for accepting, acknowledging, and responding to member grievances and requests for appeals. In addition, HSAG recommended **UHCCP** include information in the member handbook and provider manual regarding the time frame for acknowledging a grievance. Also, HSAG recommended that **UHCCP** include information related to the timely filing requirement (defined as on or before the later of the following: within 10 days of the MCE mailing the NABD; the intended effective date of the proposed ABD) for requesting continuation of benefits/services while the MCE-level appeal is pending. Furthermore, **UHCCP** will need to update the tracking and monitoring mechanism to resolve standard appeals within the required time frame. The MCE must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames:

- For standard resolution of appeals, within 30 calendar days from the day the MCE receives the appeal.
- For expedited resolution of an appeal and notice to affected parties, within 72 hours after the MCE receives the appeal.
- For notice of an expedited resolution, the MCE must also make reasonable efforts to provide oral notice of resolution.
- Written notice of appeal resolution must be in a format and language that may be easily understood by the member. **[Quality, Timeliness and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-14 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table C-14—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendations
UHCCP should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.

Response
Describe initiatives implemented based on recommendations: **UHCCP** received the Contract Year 2022-2023 Compliance Review Report on November 2, 2022. Response to all Required Corrective Actions were due on January 3, 2023. **UHCCP** has a comprehensive process for tracking any issues identified in an audit or regulatory review. This Corrections process includes tracking of each issue in an internal data warehousing system until the item is completed. To close out an item there must be evidence of completion, such as a revised document, new training content, etc. This evidence is also stored in the internal data warehousing system. A staff person on the Corrections team monitors each item with the subject matter experts to ensure timely submission of all required elements to the applicable regulatory entity. This commitment to timely completion of corrective actions positively impacts member outcomes for any corrective actions that involve a member-facing process. Utilizing the Corrections process resulted in all required responses from the Contact Year 2022-2023 Compliance Review Report were submitted by the due date of January 3, 2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable. No barriers were encountered in submitting the CAP template on time by January 3, 2023.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** will continue to use its internal Corrections process to track corrective actions to completion so that future audit deliverables continue to be submitted in a timely manner.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
UHCCP received a score of 94 percent in the Provider Selection and Program Integrity standard and 99 percent on the recredentialing record reviews. **UHCCP** maintained a credentialing and recredentialing plan. The plan outlined the process for recredentialing that complies with the requirements of the contract to ensure that the decisions are made and communicated on a timely basis. However, during the recredentialing sample record review, HSAG identified one file that reflected a delay from the recredentialing approval to notification to the provider that exceeded five months. HSAG recommended that **UHCCP** provide timely notification to providers once a recredentialing decision has been made.
Response
Describe initiatives implemented based on recommendations: **UHCCP** of NE monitors credentialing file timeliness metrics through a monthly committee meeting where such metrics are presented for health plan review. Instances in which timeliness metrics are not met will be discussed and the credentialing team will provide the health plan with steps being taken to ensure timeliness going forward.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Continue to use internal tracking mechanisms to monitor compliance with requirements.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.

Recommendations
During the sample record review, HSAG determined that one file exceeded the recredentialing time period of 36 months. **UHCCP** must follow its documented process for recredentialing within 36 months, which complies with the requirements of the contract.
Response
Describe initiatives implemented based on recommendations: The UHC Credentialing team conducted a review of the case and recredentialing policy. UHC's policy is to recredential providers every 36 months. The recredentialing notification is auto generated seven months in advance. The 36-month recredentialing timeframe is based on the previous credential date. A review of the requirements during the pandemic show that NCQA allowed a 2-month extension for recredentialing timeliness during the Public Health Emergency in which the file was in the lookback period. Nebraska credentialing requirements were also suspended by an Executive Order (EXECUTIVE ORDER No. 20-10) by the Governor of Nebraska, to waive specific statutes and regulations arising from the Uniform Credentialing Act, the Emergency Medical Services Practice Act, the Medicine and Surgery Practice Act, the Nurse Practice Act, the Pharmacy Practice Act, and the Respiratory Care Practice Act which are impairing the ability to access needed health care practitioners in Nebraska. The case did not exceed the extended recredentialing time period allowed as a result of the pandemic.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Continue to use internal tracking mechanisms to monitor compliance with requirements.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
UHCCP received a score of 75 percent in the Subcontractual Relationships and Delegation standard. HSAG recommended that **UHCCP** consistently include the Nebraska Medicaid Regulatory Appendix in its agreements to include all delegated entity requirements within the Nebraska Medicaid contract. During HSAG's review, the Nebraska Medicaid State Regulatory Appendix was not included in either of the two sample agreements provided. **UHCCP**'s two agreements did not include all provisions required by federal regulations and **UHCCP**'s contract with DHHS. **UHCCP** must ensure that all contracts and written agreements specify the following provisions: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Response
Describe initiatives implemented based on recommendations: **UHCCP** made the recommended revisions to the Nebraska Medicaid Regulatory Appendix ("Appendix") and submitted the revised document to the State of Nebraska Division of Medicaid and Long-Term Care on 12/08/2022. Approval was received on 1/20/23.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: There were no barriers, but state approval of the updated Appendix was required before we could begin work on adding the Appendix to existing subcontracts and affiliate agreements.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** of Nebraska identified a target of January 2024 to have affected subcontracts and affiliate agreements updated with the revised Appendix. **UHCCP** of Nebraska is on track to meet that target of January 2024.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Network Adequacy

Results

Network Capacity Analysis

The number of members enrolled with **UHCCP** was determined from the Medicaid enrollment data provided by DHHS. Table C-15 provides the number of eligible members in each population used to measure the adequacy of **UHCCP**'s provider network. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYNs were limited to female members 15 years of age and older.

Table C-15—Population of Eligible Members for UHCCP

Member Population	Members
Children 18 Years and Younger	67,173
Females 15 Years and Older	45,836
All Members*	131,061

*"All Members" may not equal the sum of "Children 18 Years and Younger" and "Females 15 Years and Older" as the latter categories overlap and do not include adult males. In addition, "All Members" includes members whose age was not known.

Table C-16 displays **UHCCP**'s statewide network capacity analysis results (i.e., the number of contracted providers and the provider ratios) for all applicable provider categories alongside results for pediatric specialists in appropriate provider categories. Pediatric providers were identified by a combination of taxonomy codes and provider specialties in the MCO provider data.

Table C-16—Network Capacity Analysis Results for UHCCP by Provider Category*

Provider Category	Providers	Ratio**
PCPs	1,760	1:75
PCPs, Pediatric	952	1:71
High-Volume Specialists* **		
Cardiologists	157	1:835
Cardiologists, Pediatric	13	1:5,168
Neurologists	85	1:1,542
Neurologists, Pediatric	8	1:8,397
OB/GYNs	167	1:275
Oncologists/Hematologists	67	1:1,957
Oncologists/Hematologists, Pediatric	8	1:8,397
Orthopedics	147	1:892
Orthopedics, Pediatric	5	1:13,435
Pharmacies	311	1:422
Behavioral Health Inpatient and Residential Service Providers	5	1:26,213
Behavioral Health Outpatient Assessment and Treatment Providers	1,289	1:102
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	153	1:440
Hospitals	69	1:1,900

*Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
**In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older, and pediatric providers, where the member population was limited to members 18 years of age and younger.
***High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Geographic Analysis

Table C-17 displays the percentage of **UHCCP**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table C-17—Percentage of UHCCP Members With Required Access to Care by Provider Type, Urbanicity

		UHCCP
Provider Category	**Urbanicity**	**Percentage of Members With Required Access**
PCPs	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists	Statewide	>99.9%
Neurologists	Statewide	99.7%
OB/GYNs	Statewide	99.6%
Oncologists/Hematologists	Statewide	99.5%
Orthopedics	Statewide	99.6%
Pharmacies	Urban (90%)	95.2%
	Rural (70%)	83.1%
	Frontier (70%)	98.3%
Behavioral Health Inpatient and Residential Service Providers	Urban	100.0%
	Rural	100.0%
	Frontier	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	>99.9%
	Rural	99.8%
	Frontier	97.7%
Hospitals	Statewide	80.8%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table C-18 displays the percentage of **UHCCP**'s pediatric members who have the access to care required by contract standards for all applicable provider categories and urbanicities.

Table C-18—Percentage of Pediatric UHCCP Members With Required Access to Care by Provider Category and Urbanicity*

Provider Category	Urbanicity	Percentage of Members With Required Access
PCPs, Pediatric	Urban	>99.9%
	Rural	99.9%
	Frontier	100.0%
High-Volume Specialists**		
Cardiologists, Pediatric	Statewide	91.5%
Neurologists, Pediatric	Statewide	73.8%
Oncologists/Hematologists, Pediatric	Statewide	73.1%
Orthopedics, Pediatric	Statewide	88.3%
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	Urban	97.8%
	Rural	79.0%
	Frontier	58.1%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity. The minimum access is required for 100 percent of members unless otherwise noted.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Table C-19 and Table C-20 display the percentage of **UHCCP**'s members with the access to care required by contract standards for behavioral health categories by Behavioral Health Region.

Table C-19—Percentage of UHCCP Members With Required Access to Inpatient and Residential Service Providers by Behavioral Health Region

Behavioral Health Services	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%
Region 4	100.0%

Behavioral Health Services	Percentage of Members With Required Access
Region 5	100.0%
Region 6	100.0%

Table C-20—Percentage of UHCCP Members With Required Access to Outpatient Behavioral Health Services by Population and Behavioral Health Region

Behavioral Health Services	Percentage of Members With Required Access	Percentage of Pediatric Members With Required Access
Behavioral Health Outpatient Assessment and Treatment Providers		
Region 1	100.0%	71.6%
Region 2	98.3%	44.8%
Region 3	>99.9%	90.7%
Region 4	99.7%	86.1%
Region 5	100.0%	100.0%
Region 6	100.0%	100.0%

* Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region. The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table C-21 identifies the counties where the minimum geographic access standards were not met by **UHCCP** in a specific urbanicity or Behavioral Health Region for each applicable provider category. Results are presented separately for the general and pediatric populations as appropriate.

Table C-21—Counties Not Meeting Standards for UHCCP by Urbanicity and Behavioral Health Region*

Provider Category	Counties Not Meeting Standard
PCPs	
Urban	Lincoln
PCPs, Pediatric	
Urban	Lincoln
Rural	Cherry

Provider Category	Counties Not Meeting Standard
High-Volume Specialists**	
Cardiologists	Cherry
Neurologists	Boyd, Cherry, Deuel, Dundy, Garfield, Grant, Holt, Loup, Sheridan
OB/GYNs	Cherry, Sheridan
Oncologists/Hematologists	Brown, Cherry, Grant, Holt, Keya Paha, Rock, Sheridan
Orthopedics	Brown, Cherry, Rock
High-Volume Specialists, Pediatric**	
Cardiologists, Pediatric	Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Chase, Cherry, Cheyenne, Dawes, Deuel, Dundy, Garden, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Red Willow, Richardson, Rock, Scotts Bluff, Sheridan, Sioux, Thomas
Neurologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, York
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, York
Orthopedics, Pediatric	Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Cedar, Chase, Cherry, Cheyenne, Dawes, Deuel, Dixon, Dundy, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Morrill, Perkins, Pierce, Platte, Red Willow, Richardson, Rock, Scotts Bluff, Sheridan, Sioux, Stanton, Thayer, Thomas, Wayne, Wheeler

Provider Category	Counties Not Meeting Standard
Pharmacies	
Urban	Buffalo, Dawson, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Clay, Custer, Dixon, Furnas, Holt, Knox, Nemaha, Thurston, Wayne
Frontier	Grant, Hooker, Thomas
Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Buffalo, Lincoln, Platte
Rural	Cherry
Frontier	Dundy, Grant, Hooker, Thomas
Region 2	Dundy, Grant, Hooker, Lincoln, Thomas
Region 3	Buffalo
Region 4	Cherry, Platte
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Dawson, Lincoln, Madison, Platte
Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Custer, Furnas, Harlan, Holt, Keith, Knox, Red Willow, Valley
Frontier	Arthur, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Garden, Garfield, Gosper, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Loup, Perkins, Rock, Sheridan, Thomas, Wheeler
Region 1	Box Butte, Cheyenne, Deuel, Garden, Kimball, Sheridan
Region 2	Arthur, Chase, Dawson, Dundy, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Perkins, Red Willow, Thomas
Region 3	Blaine, Custer, Furnas, Garfield, Harlan, Loup, Valley, Wheeler
Region 4	Antelope, Boone, Boyd, Brown, Cedar, Cherry, Holt, Keya Paha, Knox, Madison, Platte, Rock
Hospitals* **	
Hospitals	Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cass, Cedar, Cherry, Cheyenne, Custer, Dawes, Dawson, Dixon, Frontier, Furnas, Garden, Garfield, Grant, Greeley, Harlan, Hayes, Hitchcock, Holt, Hooker, Johnson, Keith, Keya Paha, Knox, Lancaster, Lincoln, Logan, Loup, McPherson, Nemaha, Pawnee, Perkins, Saunders, Scotts Bluff, Seward, Sheridan, Sherman, Sioux, Thomas, Thurston, Valley, Wayne, Wheeler

*Rows are only shown if at least one county did not meet the standard.
**High-volume specialists are those identified by DHHS for purposes of the geographic network distribution analysis.
***The standard for this provider category does not differ by urbanicity.

Strengths

UHCCP achieved compliance with eight of 12 network access standards by urbanicity, and its compliance rates were 97.7 percent or above for the remainder of the standards. **UHCCP** also achieved compliance with nine of 12 behavioral health access standards by Behavioral Health Region. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

Some **UHCCP** members may not have access within the standard to providers that specifically identify as having a pediatric specialty, especially with respect to behavioral health outpatient assessment and treatment providers in rural and frontier areas, where the percentages of members with access is 79.0 percent and 58.1 percent, respectively. Looking at the results by Behavioral Health Region, **UHCCP** members may not have access to pediatric outpatient behavioral health specialists within the standard, particularly in Region 2, where only 44.8 percent have the required access. For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, a lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-22 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table C-22—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
UHCCP's greatest opportunity for improvement is to strengthen its network of Behavioral Health Inpatient and Residential Services Providers available to Behavioral Health Regions, particularly in Region 2, and Behavioral Health Outpatient Providers in Behavioral Health in Region 4.
Response
Describe initiatives implemented based on recommendations: We review opportunities to strengthen our Behavioral health network annually. We review gaps in geo access reports and compare to the MLTC Provider file to identify any opportunities for recruitment. Any gaps and opportunities to enhance our network is identified in our Network Development Plan. This Plan is submitted annually to MLTC for network approval. Currently, we are meeting access standards for Behavioral Health Inpatient and Residential Treatment Centers in Region 2 and Statewide. We are currently contracted with all Behavioral Health Inpatient and Residential Treatment centers in Nebraska. We reviewed PRTF providers and have identified out of state providers and are actively recruiting to enhance our network. We are also meeting access standards in Region 4 for Behavioral Health Outpatient and Assessment with the exception of Cherry County. We have reviewed opportunities for recruitment and not found any additional providers available to contract in this county.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Currently we are meeting access standards for Behavioral Health Inpatient and Residential Treatment Centers Statewide. We are meeting access standards in Region 4 for Behavioral Health Outpatient and Assessment with the exception of Cherry County. We have reviewed opportunities for recruitment and not found any additional providers available to contract in this county.
Identify any barriers to implementing initiatives: Barriers to recruitment are lack of in-state PRTF for children with ID/ DD or high behavioral needs, leads to referrals to out of state care. Rural and frontier gaps tend to involve higher levels of care rather than psychotherapy and leads to challenges with tele-health solutioning.
Identify strategy for continued improvement or overcoming identified barriers: To Mitigate these barriers to access in Urban, Rural, and Frontier areas, we use different tactics depending on the area and situation. We identify border providers to maintain referral patterns and expand access, we use Single Case Agreements with non-contracted providers. We identify providers not enrolled in Medicaid and recruit for Medicaid participation.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
UHCCP could significantly improve access to pediatric specialists across all provider types and regions.
Response
Describe initiatives implemented based on recommendations: There is little ability to improve access to pediatric specialist across the State as the majority of pediatric specialists are located in urban settings and are a part of a Children's Medical Center. We are contracted with the 2 children's Medical Centers in the State. In addition, we have contracted with border state pediatric hospitals in Denver, and Sioux Falls South Dakota. We review access and availability reports on a quarterly basis and look to identify gaps and opportunities to fill those gaps with contracted providers.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Barriers to recruitment are lack of in-state pediatric specialists in rural and frontier counties.
Identify strategy for continued improvement or overcoming identified barriers: To mitigate these barriers, we support telehealth solutions as well as working with our Pediatric providers to develop satellite clinics so that members have access to a specialist within their communities. Additionally, we assess providers not enrolled in Medicaid and recruit for Medicaid Network participation.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.
Response
Describe initiatives implemented based on recommendations: We review opportunities to strengthen our network annually. We review gaps in geo access reports and compare to the MLTC Provider file to identify any opportunities for recruitment. Any gaps and opportunities to enhance our network is identified in our Network Development Plan. This Plan is submitted annually to MLTC for network approval.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Barriers to recruitment are lack of some specialists in rural and frontier counties.

Identify strategy for continued improvement or overcoming identified barriers: To mitigate these barriers, we support telehealth solutions as well as working with our specialist providers to develop satellite clinics so that members have access to a specialist within their communities. Additionally, we assess providers not enrolled in Medicaid and recruit for Medicaid Network participation.
HSAG Assessment: UHCCP sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Improvement Projects

Results

Clinical PIP: *First Dental Visit at Age 1*

MCNA submitted the clinical PIP, *First Dental Visit at Age 1,* focused on increasing the percentage of members who receive at least one dental service by their first birthday, for the CY 2023–2024 validation cycle. The PIP received an overall *Met* validation status with the initial submission. The MCE did not resubmit. Table D-1 summarizes **MCNA**'s PIP validation scores.

Table D-1—2023–2024 PIP Validation Results for MCNA

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
First Dental Visit at Age 1	Initial Submission	100%	100%	*Met*
	Resubmission	*Did not resubmit*		

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table D-2 presents baseline, Remeasurement 1, and Remeasurement 2 performance indicator data for **MCNA**'s *First Dental Visit at Age 1* PIP, which was used to objectively assess for improvement.

Table D-2—Performance Indicator Results for MCNA's *First Dental Visit at Age 1* PIP

Performance Indicator	Baseline (01/01/2020 to 12/31/2020)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
1. Percentage of members 1 year of age who received their first dental visit by their first birthday.	N: 366 D: 10,420	3.51%	N: 497 D: 10,504	4.73%	N: 690 D: 10,505	6.57%	*Yes*

Performance Indicator	Baseline (01/01/2020 to 12/31/2020)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
2. Percentage of members 1 year of age who received a preventive visit by their first birthday.	N: 297 D: 10,420	2.85%	N: 455 D: 10,504	4.33%	N: 654 D: 10,505	6.23%	*Yes*

N–Numerator, D–Denominator

For the baseline measurement period (calendar year 2020), **MCNA** reported that 3.51 percent of members 1 year of age received a dental visit on or before their first birthday and 2.85 percent of members in this age group received at least one *preventive* dental service on or before their first birthday.

For the first remeasurement period (CY 2021), **MCNA** reported a statistically significant increase over baseline results for performance indicators 1 and 2. For Indicator 1, the DBM reported an increase of 1.22 percentage points in the percentage of members who received their first dental visit by their first birthday, from 3.51 percent to 4.73 percent ($p < 0.0001$). For Indicator 2, the DBM reported an increase of 1.48 percentage points in the percentage of members who received their first preventive dental visit by their first birthday, from 2.85 percent to 4.33 percent ($p < 0.0001$). Sustained improvement in performance indicator results cannot be assessed until results from the second remeasurement period are reported.

For the second remeasurement period (CY 2022), **MCNA** reported a statistically significant increase over baseline results for performance indicators 1 and 2. For Indicator 1, the DBM reported an increase of 3.06 percentage points in the percentage of members who received their first dental visit by their first birthday, from 3.51 percent to 6.57 percent ($p < 0.0001$). For Indicator 2, the DBM reported an increase of 3.38 percentage points in the percentage of members who received their first preventive dental visit by their first birthday, from 2.85 percent to 6.23 percent ($p < 0.0001$). With results from two consecutive remeasurement periods demonstrating significant improvement over baseline performance, sustained improvement was also demonstrated for both indicators at Remeasurement 2.

Nonclinical PIP: *Increasing the Percentage of Providers Receiving Cultural Competency Training*

MCNA submitted the nonclinical PIP, *Increasing the Percentage of Providers Receiving Cultural Competency Training*, which focused on improving cultural competency among active network providers. The PIP received an overall *Partially Met* validation status for the initial submission. **MCNA** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table D-3 summarizes **MCNA**'s PIP validation scores.

Table D-3—2023–2024 PIP Validation Results for MCNA

PIP Title	Type of Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Percentage of Providers Receiving Cultural Competency Training	Initial Submission	94%	89%	*Partially Met*
	Resubmission	100%	100%	*Met*

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table D-4 presents baseline performance indicator data for **MCNA**'s *Increasing the Percentage of Providers Receiving Cultural Competency Training* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table D-4—Performance Indicator Results for MCNA's *Increasing the Percentage of Providers Receiving Cultural Competency Training* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Percentage of providers receiving cultural competency training	N: 45 D: 822	5.47%	N: NA D: NA	NA	N: NA D: NA	NA	*Not Assessed*

N–Numerator, D–Denominator
NA–Not Applicable

For the baseline measurement period (CY 2022), **MCNA** reported that 5.47 percent of active network providers had received cultural competency training.

Interventions

Clinical PIP: *First Dental Visit at Age 1*

For the *First Dental Visit at Age 1* PIP, **MCNA** used a fishbone diagram and results of PDSA cycles to identify the following barriers and interventions for improving performance indicator outcomes.

Table D-5 displays the barriers and interventions as documented by **MCNA** for the PIP.

Table D-5—Barriers and Interventions for the *First Dental Visit at Age 1* PIP

Barriers	Interventions
Limited oral health literacy among parents and/or caregivers of members under 1 year of age.	• Member/caregiver educational "Baby's First Toothbrush Kit" which was mailed to families when a child member turned 10 months of age. The kit included oral health educational content, a baby toothbrush, and information about scheduling the first dental checkup by the first birthday. • Postcards and text messages sent to parents reminding them to schedule the first dental visit before the child's first birthday.
Lack of awareness and/or adherence to preventive care clinical practice guidelines among providers.	Practice Site Performance Summary report distributed to providers quarterly, which included facility feedback and peer performance on the rate of 1-year-old members who had received a preventive dental service.

Nonclinical PIP: *Increasing the Percentage of Providers Receiving Cultural Competency Training*

For the *Increasing the Percentage of Providers Receiving Cultural Competency Training* PIP, **MCNA** used a fishbone diagram and results of PDSA cycles to identify the following barriers and interventions for improving performance indicator outcomes.

Table D-6 displays the barriers and interventions as documented by **MCNA** for the PIP.

Table D-6—Barriers and Interventions for the *Increasing the Percentage of Providers Receiving Cultural Competency Training* PIP

Barriers	Interventions
Low provider participation in provider webinars for cultural competency training.	Provider Relations Site Visits—Provider Relations team members incorporate cultural competency training for new and existing providers who have not completed training for the year into their routine site visits.
Providers are not available to complete training during office hours due to busy schedules and staffing shortages.	Provider Portal Cultural Competency Training—Cultural competency training were added to **MCNA**'s Provider Portal where providers can access and complete the training at their convenience.
Lack of a reminder system to inform providers of the required cultural competency training.	Targeted Provider Outreach Calls—The Provider Relations team conducts monthly calls to new and existing providers who have not completed their cultural competency training to assist with scheduling an on-site visit or inviting them to the next webinar.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **MCNA** followed a methodologically sound PIP design for the baseline and Remeasurement 2 periods that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **MCNA** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **MCNA** conducted barrier analyses to identify and prioritize barriers to improvement and initiated interventions to address priority barriers. **[Quality]**
- **MCNA** reported Remeasurement 2 results for the *First Dental Visit at Age 1* PIP that demonstrated sustained and statistically significant improvement in the percentage of members who received their first dental visit by 1 year of age, compared to baseline performance. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG did not identify any opportunities for improvement.

To support sustained improvement in the access to and timeliness of dental care for its members, HSAG offers the following recommendations for **MCNA**:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- Use ongoing collection of intervention evaluation results to support continued refinement of improvement strategies and maximize improvement in performance indicator outcomes. **[Quality]**
- Identify strategies to continue and spread successful interventions to support sustained and further improvement in performance indicator outcomes over time. **[Quality, Timeliness, and Access]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table D-7 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table D-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.

Response
Describe initiatives implemented based on recommendations: By means of **MCNA**'s quality improvement team members, quality improvement committee, and dental advisory committee, the causal/barrier analysis and prioritization of barriers is updated annually and documented in step 8 of the PIP form(s).
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: **MCNA** will continue to revisit the casual/barrier analysis and prioritization of barriers annually and accurately update the PIP form as needed.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Use ongoing collection of intervention evaluation results to support continued refinement of improvement strategies and maximize improvement in performance indicator outcomes.
Response
Describe initiatives implemented based on recommendations: On an ongoing basis, **MCNA** evaluates the outcomes of all active interventions through the PDSA cycle to determine the effectiveness of an intervention and makes modifications as needed.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: **MCNA** will continue to collect intervention evaluation results and refine as needed in order to maximize improvement in indicator outcomes.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Identify strategies to continue and spread successful interventions to support sustained and further improvement in performance indicator outcomes over time.
Response
Describe initiatives implemented based on recommendations: To support sustained and further improvement in performance indicator outcomes over time, **MCNA** continuously monitors and analyzes performance indicator data to identify trends and areas for improvement. **MCNA**'s quality team also regularly reviews and updates interventions based on changing circumstances, feedback and new data through the PDSA cycle to guide improvement efforts. Based on the data, **MCNA** makes informed decisions as to which interventions are working and which need adjustment or expansion.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: **MCNA** will continue to monitor performance indicator outcomes and modify or implement new interventions as needed in order to sustain improvement.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG evaluated **MCNA**'s data systems for processing each data type used for reporting the DHHS performance measure data. General findings are indicated below.

Results for Eligibility/Enrollment Data System Review

MCNA received enrollment files daily and monthly in the 834 file format from MLTC. **MCNA** used an automated process to retrieve the 834-files from MLTC's secure file exchange site and conducted pre-processing to ensure the files met the X12 standards for electronic data interchange (EDI). **MCNA**'s EDI Team reviewed validation reports generated during pre-processing and communicated X12 violations to MLTC by email. **MCNA** considered the 834-file as the source of truth for member enrollment data.

The 834-files that met the X12 standards were loaded into DentalTrac, **MCNA**'s proprietary dental system, and were used to update members' enrollment records. Once 834-files were loaded into DentalTrac, **MCNA**'s Eligibility and Enrollment Team reviewed the load reports to identify duplicate member records. The Eligibility and Enrollment Team verified the information of duplicate member records with a MLTC liaison by email and merged the duplicate information into a single record within DentalTrac. **MCNA**'s provider portal was updated in near-real-time to reflect members' current enrollment status and eligibility for services.

Members enrolled with **MCNA** were identified in DentalTrac by their subscriber ID and a unique system-generated ID. DentalTrac maintained members' unique system ID across their enrollment spans. Additionally, DentalTrac maintained members' unique system ID even as they moved from one state to another, as long as they remained enrolled with **MCNA**.

During the virtual review, **MCNA** demonstrated the DentalTrac system, from which HSAG confirmed the accurate collection of eligibility effective dates, termination dates, and historical eligibility spans. **MCNA** had adequate reconciliation and validation processes in place at each point of data transfer to ensure data completeness and accuracy.

HSAG identified no concerns with **MCNA**'s process for receiving and processing eligibility data.

Results for Medical Service Data System (Claims/Encounters) Review

MCNA had a standard process in place for credentialing and registering providers. Each new provider completed an application and provided license information and references to **MCNA** for review. **MCNA**'s Credentialling Team manually reviewed each provider's submission, verified the provider's Medicaid-enrollment status, and entered the provider's information and credentials in DentalTrac. The Credentialing Team reviewed providers' information in DentalTrac whenever provider data were used while conducting business. **MCNA** sent newly registered providers a welcome letter that included

instructions for accessing the provider portal. HSAG found **MCNA**'s provider data processing steps to be adequate.

MCNA received electronic claims from providers through the provider portal and a clearinghouse. Registered providers could enter service data directly into the provider portal to generate an electronic claim. Additionally, providers could submit claims in the electronic 837D format through a clearinghouse. **MCNA** retrieved the electronic claims from the clearinghouse's secure file exchange site and conducted pre-processing to ensure the files met the X12 standards. Electronic claims submitted through the provider portal or clearinghouse were then loaded into DentalTrac for adjudication.

MCNA contracted with Smart Data Solutions (SDS) to receive paper claims and convert them to the electronic 837D format. Providers mailed paper claims to the SDS location specified in the provider manual, and SDS used optical character recognition (OCR) software to convert the paper forms into electronic files. The OCR process could identify issues with the paper forms that required manual intervention; SDS loaded claims flagged during OCR to a portal accessible to **MCNA** claim reviewers to facilitate the manual review of these paper claims. SDS submitted claims converted to the electronic 837D format to **MCNA** daily through a secure file exchange site and attached a scanned copy of the paper claims. SDS stored paper claims on-site for 30 days and subsequently shredded the paper forms. Electronic claims received from SDS were then loaded into DentalTrac for adjudication.

MCNA noted that roughly 64 percent of claims loaded into DentalTrac were auto adjudicated. Claims that needed manual review were loaded into queues in DentalTrac and assigned to claim examiners or clinical reviewers. Claim examiners denied claims with missing or incorrect information as well as at the recommendation of clinical reviewers. **MCNA** conducted routine audits of claim processors and a monthly audit of the auto adjudication system to ensure the accuracy and timeliness of claim adjudication. Issues identified during the audits were communicated to and addressed with the appropriate staff members.

Following claims adjudication, service data were batched, translated into EDI 837 transaction files, and submitted to the State daily. **MCNA** retrieved 999 response files to determine whether files or records were rejected and the reason for the rejection. **MCNA** staff members would forward any errors to the appropriate **MCNA** internal business unit for review and correction. Approximately 99.8 percent of encounters were accepted by the State.

During the virtual review, **MCNA** demonstrated the DentalTrac system, from which HSAG confirmed the accurate receipt, documentation, and reconciliation of claims data. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

HSAG identified no issues with **MCNA**'s process for receiving and processing claims and encounter data.

Results for Data Integration Process Review

MCNA maintained member eligibility and service data within the DentalTrac system. **MCNA** extracted relevant eligibility and service data into the PostgresSQL database and calculated rates on performance measures using SQL code. **MCNA** then generated performance measure reports in the Microsoft (MS) Power BI tool to facilitate internal review. **MCNA**'s Quality Team reviewed denominator counts, numerator counts, and measure rates following the daily refresh of measure reports in MS Power BI. Prior to reporting, **MCNA**'s measure rates were reviewed by the information technology (IT) report analysts as well as the Business Department, Compliance Department, and the chief information officer.

MCNA reviewed its performance on measures periodically and engaged providers in efforts to improve quality. **MCNA**'s Quality Improvement Committee conducted a quarterly review of measure rates to observe trends and identify opportunities for improvement. Additionally, **MCNA** held discussions with providers as part of the Dental Advisory Committee to communicate observed trends and obtain information on potential barriers to improvement.

Prior to the virtual review, HSAG reviewed the MY 2022 rates reported by **MCNA** on the six oral health measures selected by DHHS. HSAG did not identify any issues with the reported rates but observed a steady decrease in the rate for the *Annual Dental Visit (ADV)* measure from MY 2020 to MY 2022, specifically for members 19 to 20 years old. **MCNA** confirmed this observation and noted that it has been historically difficult to follow up with 19- to 20-year-olds for dental services due to factors such as lack of parental supervision. **MCNA** deployed several interventions since MY 2022 to engage this population and improve performance on the *ADV* measure, including postcard mailings, text message campaigns, targeted outreach by phone, and gift card incentives. So far in 2023, **MCNA** has noticed an improvement in performance on the *ADV* measure compared to previous years.

During the virtual review, HSAG conducted PSV to confirm that members included in the population for performance measures met the inclusion criteria. HSAG verified member and service data in DentalTrac for select members obtained from **MCNA**'s member-level data file. Additionally, HSAG reviewed screen shots from DentalTrac provided by **MCNA** to confirm the eligibility and service information for each selected member. Based on this review, HSAG found **MCNA**'s performance measure rates to be valid and reportable.

HSAG identified no concerns with **MCNA**'s data integration and measure calculation processes for performance measure reporting.

Results for Performance Measures

Based on all validation activities, HSAG determined results for each performance measure. The CMS PMV protocol identifies possible validation finding designations for performance measures, which are defined in Table D-8.

Table D-8—Designation Categories for Performance Measures

Designation	Description
Reportable (R)	Measure was compliant with State specifications.
Do Not Report (DNR)	DBM rate was materially biased and should not be reported.
Not Applicable (NA)	The DBM was not required to report the measure.
Not Reported (NR)	Measure was not reported because the DBM did not offer the required benefit.

According to the CMS PMV protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "DNR" because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of "R."

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure as "DNR."

Table D-9 shows the key review findings and audit designations for **MCNA** for each performance measure rate.

Table D-9—Review Designations for MCNA

Performance Measure	Measure Designation
ADV: Annual Dental Visit—*The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*	R
TFL-CH-A: Prevention: Topical Fluoride for Children—*The percentage of enrolled children aged 1–21 years who received at least two topical fluoride applications within the reporting year (Rate 1).*	R
UTL-CH-A: Utilization of Services, Dental Services—*The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.*	R
TRT-CH-A: Treatment Services, Dental Service—*The percentage of enrolled children who received a treatment service within the reporting year.*	R
OEV-CH-A: Oral Evaluation, Dental Services—*The percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.*	R
CCN-CH-A: Care Continuity, Dental Services—*The percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.*	R

Table D-10—MY 2020, 2021, and 2022 Performance Measure Results for MCNA

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Results		
			Denominator	Numerator	Rate
ADV: Annual Dental Visit—*The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.*	43.48%	45.73%	21,534	10,104	46.92%
ADV: Annual Dental Visit—*The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.*	61.64%	66.13%	30,643	20,017	65.32%
ADV: Annual Dental Visit—*The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.*	65.25%	69.12%	40,291	27,879	69.19%
ADV: Annual Dental Visit—*The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.*	59.62%	61.40%	38,841	23,514	60.54%
ADV: Annual Dental Visit—*The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.*	51.13%	51.61%	35,450	17,441	49.20%
ADV: Annual Dental Visit—*The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.*	37.71%	34.16%	14,122	4,315	30.56%
ADV: Annual Dental Visit—*The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*	57.03%	58.40%	180,881	103,270	57.09%
TFL-CH-A: Prevention: Topical Fluoride for Children—*The percentage of enrolled children aged 1–21 years who received at least two topical fluoride applications within the reporting year (Rate 1).*	NR	35.50%	192,413	45,196	23.49%
UTL-CH-A: Utilization of Services, Dental Services—*The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.*	50.38%	52.73%	209,569	109,369	52.19%
TRT-CH-A: Treatment Services, Dental Service—*The percentage of enrolled children who received a treatment service within the reporting year.*	16.36%	18.36%	209,569	38,111	18.19%

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Results		
			Denominator	Numerator	Rate
OEV-CH-A: Oral Evaluation, Dental Services—*The percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.*	46.92%	49.39%	209,569	101,321	48.35%
CCN-CH-A: Care Continuity, Dental Services—*The percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.*	40.77%	37.03%	182,693	70,039	38.34%

Strengths

MCNA had sound practices in place to ensure the quality and accuracy of enrollment data from MLTC and service data from providers. Additionally, **MCNA** had sound processes for integrating data for reporting, calculating performance measure rates, and reviewing rates prior to reporting. **[Quality]**

MCNA facilitated the provision of timely dental services by ensuring providers had near-real-time access to current eligibility data and were aware of existing gaps in care. Additionally, **MCNA** used several methods to educate members about oral health and encourage the utilization of dental services, including: **[Quality and Access]**

- Educational materials sent through postal mail, by text, or by phone.
- Social media campaigns.
- The MYMCNA smartphone application and the **MCNA** website.

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement related to the accuracy of **MCNA**'s performance measure data during the 2023 PMV review.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table D-11 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table D-11—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations
MCNA noted during the review that it is continuing to exercise HSAG's recommendations from last year as **MCNA** works with its provider network to identify optimal office hours to ensure members can receive preventive services. Additionally, **MCNA** is continuing to monitor its rates over time to identify pandemic rate impact, ensuring lower access to preventive care is not being driven by a non-pandemic issue. **MCNA** indicated that it is in constant contact with providers to ensure member access is a priority. A backlog of patients still exists for many providers as a result of the PHE, but **MCNA** stated the backlog is slowly being reduced based on member availability and member priorities to attend appointments. **MCNA** is anticipating the backlog will be alleviated by August 2023.
Response
Describe initiatives implemented based on recommendations: Based upon HSAG recommendations, **MCNA**'s Provider Relations Team conducts ongoing education to providers via quarterly training, site visits, and the monthly provider newsletter regarding best practices for scheduling members' next appointments as they leave the provider's office and identifying the optimal business hours to ensure members are receiving preventative care. **MCNA** has cultivated an open dialogue with Nebraska Providers and the Provider Relations Team regarding eliminating any backlog of patients as a result of the PHE including discussions regarding a reduction of any patient backlog to optimize access of care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As a result of ongoing education and direct contact with our providers, the PHE backlog was eliminated and providers are back working their normal schedules.
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: Based upon HSAG recommendations, **MCNA** will continue to employ the Nebraska Provider Relations Team to regularly engage the Nebraska Provider Community in robust conversations regarding scheduling members effectively, identifying optimal business hours, barriers to access of care, and the reduction of any backlog due to non-pandemic matters.
HSAG Assessment: **MCNA** sufficiently addressed CY 2022–2023 recommendations. **MCNA** facilitated the provision of timely dental services by ensuring providers had near-real-time access to current eligibility data and were aware of existing gaps in care. Additionally, **MCNA** used several methods to educate members about oral health and to encourage the utilization of dental services, including educational materials sent through postal mail, by text, or by phone; social media campaigns; and the MYMCNA smartphone application and the **MCNA** website.
Recommendations
For MY 2021, **MCNA**'s rates for the NCQA *Annual Dental Visit—19–20 Years of Age* and for the DQA *Care Continuity, Dental Services* measures decreased. **MCNA** contributed the *Annual Dental Visit—19–20 Years of Age* rate decrease to a volatile age group. **MCNA** noted that members in this age group typically lack parental supervision and are less likely to follow up on services conducted during their adolescence. **MCNA** also discussed that the *Care Continuity, Dental Services* measure rate decrease was due to office closures and members seeing a different practice based on service availability. Members under the *Care Continuity, Dental Services* measure would not have been counted toward the numerator for the measure if members did not follow up with the same practice for consecutive services. HSAG recommended that **MCNA** work with providers to illustrate the importance of scheduling members immediately after they receive dental services to

ensure an appointment has been set before they leave the office. After members leave the office, it becomes difficult to schedule them through follow-up communications. With a backlog of scheduled patients, providers should try to schedule college-aged members during time frames most convenient for that age group, taking personal schedules into consideration (e.g., school, work) to optimize their availability. **MCNA** should also remind providers to use dental provider software or office staff to send out automatic reminders via email or text message if a member has missed a follow-up visit or is past due for service.

Response

Describe initiatives implemented based on recommendations: Based off HSAG recommendations, **MCNA** has optimized its provider relations team to ensure a proper dialogue with providers includes illustrating the importance of scheduling members immediately after they receive dental services to ensure an appointment has been set before they leave the office. After members leave the office, it becomes difficult to schedule them through follow-up communications.

Based off HSAG recommendations, **MCNA** has optimized its provider relations team to ensure a proper dialogue with providers includes a reflection on the realities of a day-to-day dental practice, whereby a backlog of scheduled patients can present itself. And even in the face of this potential event, providers should try to schedule college-aged members during time frames most convenient for that age group, taking personal schedules into consideration (e.g., school, work) to optimize their availability.

Based off HSAG recommendations, **MCNA** has optimized its provider relations team to ensure a proper dialogue with providers includes encouraging providers to use dental provider software or office staff to send out automatic reminders via email or text message if a member has missed a follow-up visit or is past due for service.

Based off HSAG recommendations, **MCNA** will routinely send out provider bulletins / newsletters that advocate:

A. The importance of scheduling members immediately after they receive dental services to ensure an appointment has been set before they leave the office. After members leave the office, it becomes difficult to schedule them through follow-up communications.

B. A reflection on the realities of a day-to-day dental practice, whereby a backlog of scheduled patients can present itself. And even in the face of this potential event, providers should try to schedule college-aged members during time frames most convenient for that age group, taking personal schedules into consideration (e.g., school, work) to optimize their availability.

C. Encouraging providers to use dental provider software or office staff to send out automatic reminders via email or text message if a member has missed a follow-up visit or is past due for service.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): No performance improvements applicable in view of the best practice two allow for 24 months person-time pre/post intervention. By December 2023 we will have a decent, informative picture of efforts.

Identify any barriers to implementing initiatives: There were no barriers identified.

Identify strategy for continued improvement or overcoming identified barriers: **MCNA**'s strategy for continued improvement or overcoming identified barriers remains to be rooted in data integrity in that **MCNA** strives to capture events that aim to promote continued improvement and the outcome events thereof. Further, **MCNA** endeavors to maintain a plan of action that ensures the providers in its network are heard and reconciled in the name of health outcomes while alleviating burdens on the provider.

HSAG Assessment:

MCNA sufficiently addressed the CY 2022–2023 recommendations regarding the *Annual Dental Visit—19–20 Years of Age* measure indicator. **MCNA**'s performance on the *Annual Dental Visit—19–20 Years of Age*

measure indicator declined from MY 2021 to MY 2022; however, **MCNA** launched several campaigns to encourage members ages 19 to 20 years to conduct their annual dental visits, including postcard mailings, text message campaigns, targeted outreach by phone, and gift card incentives. **MCNA** anticipates that these efforts will result in an improved MY 2023 rate on this measure indicator.

MCNA sufficiently addressed the CY 2022–2023 recommendations regarding the *Care Continuity*, *Dental Services* measure. **MCNA**'s performance on the *Care Continuity*, *Dental Services* measure improved from MY 2021 to MY 2022.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table D-12—Compliance With Regulations—Trended Performance for MCNA

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**	Year Three (2023–2024)**
Standard Number and Title	**MCNA Results**		
Standard I—Enrollment and Disenrollment	100%	100%	
Standard II—Member Rights and Confidentiality	83%		100%
Standard III—Member Information	77%		95%
Standard IV—Emergency and Poststabilization Services	100%	100%	
Standard V—Adequate Capacity and Availability of Services	86%		100%
Standard VI—Coordination and Continuity of Care	100%		100%
Standard VII—Coverage and Authorization of Services	84%		100%
Standard VIII—Provider Selection and Program Integrity	94%	94%	
Standard IX—Subcontractual Relationships and Delegation	100%	75%	
Standard X—Practice Guidelines	100%	100%	
Standard XI—Health Information Systems	100%	100%	
Standard XII—Quality Assessment and Performance Improvement	100%	100%	
Standard XIII—Grievance and Appeal System	77%		92.3%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.

**Grey shading indicates standards for which no comparison results are available.

Strengths

MCNA submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Four out of six standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

MCNA achieved full compliance in the Member Rights and Confidentiality standard, indicating members are receiving timely and adequate access to information that can assist them in accessing care and services. **[Access]**

MCNA achieved full compliance in the Adequate Capacity and Availability of Services standard, demonstrating the MCE maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**

MCNA achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for its care management program. **[Quality, Timeliness, and Access]**

MCNA achieved full compliance in the Coverage and Authorization of Services standard, demonstrating the MCE had a thorough and comprehensive approach for review, authorization, and denial of services. **[Timeliness and Access]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

MCNA should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

MCNA received a score of 95 percent for the Member Information standard. HSAG recommended that **MCNA** assess the website and correct the contrast errors. The contrast errors were mainly attributed to the company logos or colors used in branding with white font on a light orange background. Also, the MCE must update the member handbook informing members of the definition of "State fair hearing." **[Access]**

MCNA received a score of 92.3 for the Grievance and Appeal System standard. HSAG recommended that **MCNA** update all applicable documents to remove the notice of action terminology and replace with revised federal language to state NABD/ABD. Additionally, HSAG identified in the Appeals policy that **MCNA** did not include the federal definition of an appeal. HSAG recommended that **MCNA** update the appeal definition in all applicable policies and documents to align with the federal definition and State requirements. Additionally, HSAG recommended that **MCNA** review its policies, documents,

manuals, and member handbook to specify the accurate time frame for acknowledging receipt of a member appeal in writing. Furthermore, MCNA must ensure that for all grievances (i.e., any expression of dissatisfaction, complaints), even if the matter is immediately resolved, the proper procedures are followed to resolve each grievance and provide notice as expeditiously as the member's health condition requires, within 90 calendar days from the day on which the MCE receives the grievance. If any expression of dissatisfaction is present, MCNA must classify and treat the matter as a grievance, report to the State, follow the requirements for grievance acknowledgement, provide resolution, and ensure that members are granted their full rights. **[Quality, Timeliness, and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table D-13 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table D-13—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendations
MCNA should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.
Response
Describe initiatives implemented based on recommendations: MCNA's Compliance team reviews all findings and recommendations and coordinates with each business owner to assure that findings are remediated. Remediated items are monitored to confirm continued compliance.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: N/A
HSAG Assessment: MCNA sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Additionally, during the credentialing record review, HSAG found one sample record that had a credentialing committee review date and decision date that occurred on January 28, 2021. However, the committee decision date was entered into the records and signed as January 28, 2020. During the interview, MCNA staff members reported that the year was documented in error and should have been entered into the records and signed as January 28, 2021. HSAG recommends that MCNA implement a quality check mechanism to review the credentialing and re-credentialing documents to ensure record accuracy and completeness.
Response
Describe initiatives implemented based on recommendations: Quality audit checks were being conducted at the time of this oversight.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Quality Audit team is paying close attention to the dates on the checklist.

Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: To continue paying attention to the dates on the checklist.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
Also, during the sample credentialing record review, HSAG found the following: • Credentialing record #10 included a provider application (attestation) date of August 2, 2021, and **MCNA** credentialing staff members performed work on the application on August 12, 2021. The approval date was December 22, 2021, which was also the signature date. HSAG noted a delay of more than four months from the application date to the credentialing decision date; therefore, the credentialing time period exceeded 30 days.
Response
Describe initiatives implemented based on recommendations: Two additional coordinators were hired as well as implementing daily monitoring of the assignment log to ensure applications are processed within 30 days.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Credentialing applications are being processed and completed within 30 days.
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: Continued daily monitoring of applications assigned and bi-weekly meetings with the staff to identify any potential barriers they may have.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
MCNA must follow its credentialing policies and procedures that comply with the requirements of the contract to ensure that **MCNA** completes processing of credentialing applications from the provider within 30 calendar days of receipt of a completed credentialing application.
Response
Describe initiatives implemented based on recommendations: Two additional coordinators were hired as well as implementing daily monitoring of the assignment log to ensure applications are processed within 30 days.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Credentialing applications are being processed and completed within 30 days.
Identify any barriers to implementing initiatives: There were no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: Continued daily monitoring of applications assigned and bi-weekly meetings with the staff to identify any potential barriers they may have.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.

Validation of Network Adequacy

Results

Network Capacity Analysis

The number of members enrolled with **MCNA** was determined from the Medicaid enrollment data provided by DHHS. Table D-14 provides the number of eligible members in each population used to measure the adequacy of **MCNA**'s provider network. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists (i.e., pediadontists) were limited to children, defined as members 18 years of age and younger.

Table D-14—Population of Eligible Members for MCNA

Member Population	Members
Children 18 Years and Younger	201,153
All Members*	393,019

*"All Members" includes members whose age was not known.

Table D-15 displays **MCNA**'s statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for all applicable provider categories.

Table D-15—Network Capacity Analysis Results for MCNA by Provider Category*

Provider Category	Providers	Ratio**
General Dentists	569	1:691
Oral Surgeons	18	1:21,835
Orthodontists	30	1:13,101
Periodontists	16	1:24,564
Pediadontists	55	1:3,658

*Provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
**In calculating the ratios, all covered members were considered except in the case of pediadontists (pediatric dentists), where the member population was limited to members 18 years of age and younger.

Geographic Access Standards

Table D-16 displays the percentage of members with the access to care required by geographic access standards for all applicable dental provider categories and urbanicities for **MCNA**.

Table D-16—Percentage of Members With Required Access to Dental Care by Provider Type and Urbanicity*

Provider Category	Urbanicity	MCNA
		Percentage of Members With Required Access
General Dentists	Urban	100.0%
	Rural	>99.9%
	Frontier	100.0%
Oral Surgeons	Urban	87.0%
	Rural	62.6%
	Frontier	21.3%
Orthodontists	Urban	93.4%
	Rural	73.1%
	Frontier	85.0%
Periodontists	Urban	74.7%
	Rural	37.1%
	Frontier	0.0%
Pediadontists	Urban	99.5%
	Rural	82.5%
	Frontier	86.9%

*Red cells indicate that minimum geographic access standards were not met by **MCNA** for a specific provider category in a specific urbanicity. The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Provider Category and Urbanicity

Table D-17 identifies the counties where the minimum geographic access standards were not met by **MCNA** in a specific urbanicity for each applicable provider category.

Table D-17—Counties Not Meeting Standards for MCNA by Urbanicity

Provider Category	Counties Not Meeting Standard
General Dentists	
Rural	Cherry
Oral Surgeons	
Urban	Buffalo, Dawson, Dodge, Gage, Lincoln, Madison, Platte, Scotts Bluff

Provider Category	Counties Not Meeting Standard
Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Colfax, Cuming, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Merrick, Nance, Nemaha, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Valley
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas, Wheeler
Orthodontists	
Urban	Dakota, Dawson, Gage, Lincoln, Madison, Platte
Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Custer, Dawes, Dixon, Holt, Jefferson, Knox, Merrick, Nance, Nemaha, Pawnee, Pierce, Polk, Richardson, Stanton, Thayer, Valley, Wayne
Frontier	Boyd, Brown, Keya Paha, Rock, Sheridan, Wheeler
Periodontists	
Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Pediadontists	
Urban	Dawson, Gage, Lincoln, Platte
Rural	Box Butte, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nemaha, Pawnee, Red Willow, Richardson, Thayer, Valley
Frontier	Boyd, Brown, Dundy, Keya Paha, Rock, Sheridan

*Rows are only shown if at least one county did not meet the standard.

Strengths

MCNA's network met geographic access standards for general dentists in urban and frontier counties, and narrowly failed to meet the standard in rural counties by less than 0.1 percentage points. **MCNA** also achieved a high level of access to pediadontists in urban counties, with 99.5 percent of members having a provider within the required 45 miles. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

MCNA did not meet standards in any urbanicity for pediadontists or for any of the dental specialty provider categories. The three greatest deficits in access were for periodontists in rural counties (37.1 percent with access within 60 miles) and frontier counties (no members with access within 100 miles), and oral surgeons in frontier counties (21.3 percent of members with access within 100 miles). For all other specialties, at least 60 percent of members had access to care within the geographic access standards. For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, a lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table D-18 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2022–2023 recommendations. Please note that the responses in this section were provided by the MCE and have not been edited or validated by HSAG.

Table D-18—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
MCNA's greatest opportunity for improvement is to strengthen its network of Dental Specialists and Pediatric specialists across the state.
Response
Describe initiatives implemented based on recommendations: **MCNA**'s Network Development team updates the list of non-contracted providers in the state of NE on annual basis in an effort to identify if any new specialists or Pediatric dentists that have moved into the state or opened any new practices. The Network Development uses several resources, such as NPI Listing, NE State Board of Dentistry listings and NE State Dental Association member listings. Upon identification of any new providers identified, the Network Development team reaches out to all non-contracted providers at least three times per year in an effort to contract with any dental specialists or Pediatric dentists that may be interested in participating in the **MCNA** Network. The Network Development team has also offered enhanced fee compensation in an effort to increase the participation of specialists and pediatric dentists.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): No noted improvements were made as a result of initiatives implemented as very few specialists reside in the rural and frontier areas of the State. There is also a lack of willingness from specialists to participate in the NE Medicaid network.

Recommendations
Identify any barriers to implementing initiatives: Many of the rural and frontier states are considered shortage areas and there are no specialists or Pediatric dentists in the majority of these areas. In the counties where there are specialists and/or Pediatric Dentists, many will not participate in Medicaid Managed Care regardless of the willingness of **MCNA** to negotiate higher reimbursement fees.
Identify strategy for continued improvement or overcoming identified barriers: **MCNA**'s Network Development team continues to recruit and or identify new providers in these areas and/or identify whether any new dental providers have moved into the area for contracting opportunities. During 2023, **MCNA** offered and negotiated higher reimbursement fees in an effort to entice Specialists to participate in the network.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.
Recommendations
For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.
Response
Describe initiatives implemented based on recommendations: **MCNA** has assessed that there is a lack of providers that are in this area and/or there is a lack of willingness to participate in the Medicaid network.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: Lack of providers and lack of willingness to participate in the Medicaid network.
Identify strategy for continued improvement or overcoming identified barriers: N/A as the **MCNA**'s contract will end in 2023.
HSAG Assessment: **MCNA** sufficiently addressed the CY 2022–2023 recommendations.

Appendix E. Information System Standards

Overview of the HEDIS Compliance Audit

Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. Organizations seeking NCQA accreditation or wishing to publicly report their HEDIS performance results undergo an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization. The audits are conducted in compliance with NCQA's *HEDIS MY 2022 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the organizations are reliable, valid, accurate, and can be compared to one another.

During the HEDIS audit, data management processes were reviewed using findings from the NCQA HEDIS Roadmap review, interviews with key staff members, and a review of queries and output files. Data extractions from systems used to house production files and generate reports were reviewed, including a review of data included in the samples for the selected measures. Based on validation findings, the LOs produced an initial written report identifying any perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement. The LOs also produced a final report with updated text and findings based on comments concerning the initial report.

The FAR included information on the organization's IS capabilities; each measure's reportable results; MRR validation results; the results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and opportunities and recommendations for improvement of data completeness, data integrity, and health outcomes.

Information Systems Standards

Listed below are the Information Systems Standards published in NCQA's *HEDIS MY 2022 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

IS 1.1 Industry standard codes (e.g., International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM], International Classification of Diseases, Tenth Revision, Procedure Coding System [ICD-10-PCS], Current Procedural Terminology [CPT], Healthcare Common Procedure Coding System [HCPCS]) are used and all characters are captured.

IS 1.2 Principal codes are identified and secondary codes are captured.

IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

IS 1.4 Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.

IS 1.5 Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for measure reporting.

IS 1.6 The organization continually assesses data completeness and takes steps to improve performance.

IS 1.7 The organization regularly monitors vendor performance against expected performance standards.

Rationale

The organization must capture all clinical information pertinent to the delivery of services to provide a basis for calculating measures. The audit process ensures that the organization consistently captures sufficient clinical information. Principal among these practices and critical for computing clinical measures is consistent use of standardized codes to describe medical events, including nationally recognized schemes to capture diagnosis, procedure, diagnosis related group (DRG), and Diagnostic and Statistical Manual of Mental Disorders (DSM) codes. Standardized coding improves the comparability of measures through common definition of identical clinical events. The organization must cross-reference nonstandard coding schemes at the specific diagnosis and service level to attain equivalent meaning. The integrity of measures requires using standard forms, controlling receipt processes, editing and verifying data entry, and implementing other control procedures that promote completeness and accuracy in receiving and recording medical information. The transfer of information from medical charts to the organization's databases should be subject to the same standards for accuracy and completeness.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

IS 2.1 The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.

IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

IS 2.3 The organization continually assesses data completeness and takes steps to improve performance.

IS 2.4 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Controlling receipt processes, editing and verifying data entry, and implementing other control procedures to promote completeness and accuracy in receiving and recording member information are critical in databases that calculate measures. Specific member information includes age, gender,

benefits, product line (commercial, Medicaid, and Medicare), and the dates that define periods of membership so gaps in enrollment can be determined.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

IS 3.1 Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting.

IS 3.2 The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.

IS 3.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

IS 3.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 3.5 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Controlling receipt processes, editing and verifying data entry, and implementing other control procedures to promote completeness and accuracy in receiving and recording provider information are critical in databases that calculate measures. Specific provider information includes the provider's specialty, contracts, credentials, populations served, date of inclusion in the network, date of credentialing, board certification status, and information needed to develop medical record abstraction tools.

IS 4.0—MRR Processes—Sampling, Abstraction, and Oversight

IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).

IS 4.2 Retrieval and abstraction of data from medical records are reliably and accurately performed.

IS 4.3 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.

IS 4.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 4.5 The organization regularly monitors vendor performance against expected performance standards.

Rationale

MRR validation ensures that record abstraction performed by or on behalf of the entity meets standards for sound processes and that abstracted data are accurate. Validation includes not only an over-read of

abstracted medical records but also a review of MRR tools, policies, and procedures related to data entry and transfer, and materials developed by or on behalf of the entity.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

IS 5.2 The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.

IS 5.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

IS 5.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 5.5 The organization regularly monitors vendor performance against expected performance standards.

IS 5.6 Data approved for ECDS reporting met reporting requirements.

IS 5.7 NCQA-validated data resulting from the DAV program met reporting requirements.

Rationale

Organizations may use a supplemental database to collect and store data, which is then used to augment rates. These databases must be scrutinized closely since they can be standard, nonstandard, or member-reported. The auditor must determine whether sufficient control processes are in place related to data collection, validation of data entry into the database, and use of these data. Mapping documents and file layouts may be reviewed as well, to determine compliance with this standard. Beginning with HEDIS 2014, NCQA provided new validation requirements for auditing supplemental data to ensure that all data included for reporting are complete and have required supporting documentation.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

IS 6.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.

IS 6.2 Data transfers to HEDIS repository from transaction files are accurate.

IS 6.3 File consolidations, extracts, and derivations are accurate.

IS 6.4 Repository structure and formatting are suitable for measures and enable required programming efforts.

IS 6.5 Report production is managed effectively and operators perform appropriately.

IS 6.6 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Prior to data integration and reporting, it is essential that data transfer, consolidation, and control procedures support the integrity of the measure reporting. The organization's quality assurance practices and backup procedures serve as an organizational infrastructure supporting all information systems. The

practices and procedures promote accurate and timely information processing and data protection in the event of a disaster.

IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

IS 7.1 Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.

IS 7.2 Report production is managed effectively and operators perform appropriately.

IS 7.3 Measure reporting software is managed properly with regard to development, methodology, documentation, version control, and testing.

IS 7.4 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Calculating rates requires data from multiple sources. The systems used to assemble the data and to make the required calculations should be carefully constructed and tested. Data needed to calculate measures are produced by the organization's information systems and may be directly or indirectly affected by IS practices and procedures.