IPRO

Better healthcare, realized.

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

Annual External Quality Review Technical Report
Aggregate Report

Measurement Year 2017
April 2018

Table of Contents

List of Tables

Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 established that State agencies contracting with the following Managed Care Entities (MCEs), provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the State agency and the MCE: Medicaid Managed Care Organizations (MCOs), Prepaid Ambulatory Health Plans (PAHPs), Prepaid Inpatient Health Plans (PIHPs), and Primary Care Case Management (PCCM). Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCEs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCE. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS). Quality, as it pertains to an EQR, is defined in 42 CFR 438.320 as "The degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional, evidence-based knowledge."

These same Federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCEs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCEs regarding health care quality, timeliness and access, as well as make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCEs. Note that this report for the Nebraska Medicaid program references MCOs, as opposed to MCEs, as all three NE Medicaid organizations subject to review in measurement year (MY) 2017 are classified as MCOs.

To meet these Federal requirements, the Nebraska Department of Health and Human Services (NE DHHS) has contracted with Island Peer Review Organization (IPRO), an external quality review organization, to conduct the annual EQR of the MCOs.

Scope of EQR Activities Conducted

Generally, the EQR technical report focuses on three federally mandated activities, as set forth in 42 CFR 438.358; compliance review, validation of performance measures and validation of performance improvement projects. This aggregate technical report, however, does not include validation of performance measures, since the three MCOs entered into a new contract with the State under Heritage Health, which was not initiated until January 1, 2017, and thus performance measures were not available in time for validation. Performance measure validation will take place in 2018, and be reflected in the aggregate technical report for MY 2018.

EQR activities for MY 2017 were:

Compliance Review – This review determines MCO compliance with its contract and with State and Federal regulations in accordance with the requirements of 42 CFR 438 Subpart E.

Validation of Performance Improvement Projects (PIPs) – PIP proposals were reviewed to ensure that the projects were designed in a methodologically sound manner, allowing the possibility for meaningful improvements in care and services.

CMS defines *validation* in the Final Rule in 42 CFR 438.320 as "The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of the EQR activities performed by IPRO are detailed in the section titled Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access.

Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding Nebraska Medicaid MCOs' strengths and IPRO's recommendations with respect to quality, timeliness and access. Specific findings, strengths and recommendations are described in detail in the section titled Findings, Strengths and Recommendations with Conclusions Related to health Care Quality, Timeliness and Access of this report.

Nebraska Total Care

Quality

The quality domain encompasses PIP activities and findings from 5 of the 7 compliance domains (Member Services and Education, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management).

PIPs

In 2017, NTC submitted proposals for 3 PIP topics; Improving Follow-up After ED Visit for Mental Health Illness or Substance Use Disorder, Initiation of 17p in Pregnant Women, and Tdap Vaccination for Pregnant Women. Analysis of NTC's baseline data showed 7 and 30 day follow-up rates for HEDIS® measure FUM (44.7% and 64.4%, respectively) to be higher than the statewide average, however there is opportunity for improvement, as the MCO seeks to improve these rates over the course of this two year PIP. The PIP goals are to increase the FUM 7 and 30 day rates to 65.0% and 87.5% respectively, and increase the FUA 7 and 30 day rates to 19.6% and 25.7%, respectively (from the baseline of 4.6% and 6.9%). For 17p initiation, the MCO's baseline rate is 20.6%, with a goal of 35%. Lastly, for Tdap in pregnant women, the baseline rate for receipt of Tdap at any point in pregnancy is 53%, whereas the baseline for receipt of Tdap during the optimal 27-36 week gestational age period is 46%. The MCO is looking to increase these rates to 65% and 58%, respectively. As a means to continually monitor MCO PIP performance, Quality Improvement Committee meetings take place once a month, wherein the NE MCOs and DHHS Division of Medicaid Long Term Care meet to discuss PIP progress and barriers to-date.

Compliance Review

NTC received a "substantial compliance" designation for Member Services and Education, Grievances and Appeals, Quality Management, and Utilization Management. NTC received a "minimal compliance" designation for Subcontracting.

- Of the 10 standards/substandards reviewed for Member Services and Education, eight (8) were fully compliant and two (2) were substantially compliant. The following details findings from the review of these substantially compliant standards:
    - NTC did not provide reports that contained evidence that provider adequacy for the I/T/U providers is being tracked or measured.
    - The Member Materials Readability and Translation Policy and Procedure does not include alternative formats, such as Braille, large print and audio.

- Of the 15 standards/substandards reviewed for Grievances and Appeals, 12 were fully compliant, two (2) were substantially compliant and one (1) was minimally compliant. The following details findings from the review of these substantially and minimally compliant standards:
  Substantially Compliant Standards
    - Five (5) out of 9 applicable appeal files contained evidence that the individual completing the review was not the same involved in previous levels of review/decision making. Four (4) appeal files did not meet the requirement because the individual who did the review could not be determined.
    - For the requirement of confirmation of verbal appeal inquiries in writing, nine (9) out of 10 appeals case files were deemed not applicable because they contained inquiries in writing. The remaining one (1) appeal file did not meet the requirement because there was no evidence of the inquiry for the appeal in the file.
  Minimally Compliant Standard
    - Ten (10) out of 10 appeal files did not have language specifically stating that members could present evidence in person.

- Of the 25 standards/substandards reviewed for Quality Management, 23 were fully compliant and two (2) were substantially compliant. The following details findings from the review of these substantially compliant standards:
  - Information regarding the QAPI program can be found on the Member Resources page of the NTC website. The Member Handbook contains a broad description of the QI Program. There does not appear to be information about how the member can contact the plan regarding QI opportunities and questions.
  - NTC submitted their MAC report on time to MLTC. Member addresses were not indicated within this report.

- Of the 32 standards/substandards reviewed for Utilization Management, 29 were fully compliant and three (3) were substantially compliant. The following details findings from the review of these substantially compliant standards:
  - A report evaluating under and over utilization by race, ethnicity, gender and age was not available.
  - NTC did not submit any reports that evaluated for off-label drug usage, although two policies were submitted that contained a description of the procedures for evaluating the need for this usage among their membership.
  - A report demonstrating that emergency service utilization is being monitored by provider and member was not available.

- Of the three (3) standards/substandards reviewed for Subcontracting, one (1) was substantially compliant and two (2) were minimally compliant. The following details findings from the review of these substantially and minimally compliant standards:
  Substantially Compliant Standard
  - Of the 17 contracts reviewed, only 10 had effective dates in the review period. Nine (9) of 10 met the requirement stipulating that the MCO must evaluate the subcontractor's ability to perform the activities to be delegated. One (Morpace) did not contain evidence that a pre-delegation evaluation was carried out.
  Minimally Compliant Standards
  - Ten (10) out of 17 subcontractors met the requirement that demonstrates that the MCO monitored their performance on an ongoing basis. There was no evidence provided of ongoing monitoring for 7 subcontractors.
  - For the requirement pertaining to the identification of subcontractor deficiencies by the MCO and subsequent corrective action plan, it was impossible to tell if 7 of 17 NTC subcontractors contained corrective action plans and effective follow-up because of the lack of evidence of monitoring for these subcontractors (mentioned above).

In the domain of quality, IPRO recommends that NTC:

- Track and measure provider adequacy to ensure timely access for eligible members.
- Include alternative formats in their Member Materials Readability and Translation Policy and Procedure, either in a new sentence or by citing and attaching the Language Sheet and Statement of Non-Discrimination within the policy.
- Reference the individual who conducted the review within all appeal files, to ensure that this individual was not involved in a previous level of review or decision-making.
- In cases of verbal inquiries seeking to appeal, confirm these inquiries in writing.
- Include language in appeal files that states that the member can present evidence in person.
- In order to fully meet the requirement pertaining to the availability of QAPI information to its members, NTC should consider including language in the Member Handbook that allows members the opportunity to ask questions about the QI Program (including the contact information for whom they can contact to ask these questions), as well as where they can find information on NTC's progress in meeting goals (i.e., NTC's website).
- Include member addresses within the MAC report that is submitted semi-annually to MLTC.

- Report utilization by race, ethnicity, gender and age, and make this report available for review during the subsequent (2018) compliance audit.
- Provide a report demonstrating that off-label drug use is being monitored, and make this report available for review during the subsequent (2018) compliance audit.
- Provide a report that monitors emergency services utilization by provider and member, and have methods for addressing inappropriate utilization.
- Ensure that pre-delegation evaluation is conducted and documented.
- Establish an ongoing and annual audit schedule and convene a vendor management committee to review the results of each vendor audit.

Timeliness
The timeliness domain includes findings from two (2) of the seven (7) compliance domains; Utilization Management (UM) and Grievances and Appeals. All UM and Grievance and Appeal files reviewed demonstrated that elements were completed on time.

Access
The access domain includes findings from two (2) of the seven (7) compliance domains; Care Management and Provider Network.

NTC received a "substantial compliance" designation for Care Management and Provider Network.

- Of the 44 standards/substandards reviewed for Care Management, four (4) were substantially compliant. The following details findings from the review of these substantially compliant standards:
  - Twenty (20) care management files were reviewed. Of the 19 applicable files, three (3) did not include a risk stratification level.
  - Of the 20 files reviewed, five (5) provided evidence of collaboration with provider, one (1) file did not provide evidence of collaboration, and 14 files were not applicable.
  - The MCO has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.
  - The staff training documents that were provided do not address barriers members may experience in making and keeping appointments.

- Of the 27 standards/substandards reviewed for Provider Network, two (2) were substantially compliant and one (1) was minimally compliant. The following details findings from the review of these standards:
  Substantially Compliant Standards
  - The provider network department does not monitor "no show" rates.
  - The provider network department does not monitor the practice of placing members who seek any covered services on waiting lists.
  Minimally Compliant Standard
  - Geo Access for Medicaid indicated that access to many key services/providers for the majority of members in rural areas is insufficient, i.e., did not meet the standards specified in the contract.

In the domain of access, IPRO recommends that NTC:

- Include the assigned risk stratification level within the care management files.
- Include evidence of collaboration and communication with other providers in the care management file, as appropriate to the member's needs.
- Identify and partner with practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.
- Develop staff training specific to barriers members may experience in making and keeping appointments.
- Have a process in place to monitor and reduce appointment "no show" rates by provider and service type.
- Have a process in place to monitor waiting lists for members who seek covered services.

- Continue its recruiting efforts to increase adequacy in the areas lacking access. NTC should work with MLTC to address gaps in adequacy.

UnitedHealthcare Community Plan of Nebraska

Quality

The quality domain encompasses PIP activities and findings from five (5) of the seven (7) compliance domains (Member Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management).

PIPs

In 2017, the MCO submitted proposals for 3 PIP topics; Improving Follow-up After ED Visit for Mental Health Illness or Substance Use Disorder, Initiation of 17p in Pregnant Women, and Tdap Vaccination for Pregnant Women. Analysis of UHCCP's baseline data showed 7 and 30 day follow-up rates for HEDIS® measures FUM (64.9% and 77.2%, respectively) and FUA (24.7% and 27.0%, respectively) to be markedly higher than the statewide average, however there is opportunity for improvement, as the MCO seeks to improve these rates over the course of this two year PIP. The PIP goals are to increase the FUM 7 and 30 day rates to 78.9%, and increase the FUA 7 and 30 day rates to 30.4% and 33.2%, respectively. For 17p initiation, the MCO's baseline rate is 18.2%, with a goal of 22.7%. Lastly, for Tdap in pregnant women, the baseline rate for receipt of Tdap at any point in pregnancy is 63.8%, whereas the baseline for receipt of Tdap during the optimal 27-36 week gestational age period is 56.8%. The MCO is looking to increase these rates to 85% and 75%, respectively. As a means to continually monitor MCO PIP performance, Quality Improvement Committee meetings take place once a month, wherein the NE MCOs and DHHS Division of Medicaid Long Term Care meet to discuss PIP progress and barriers to-date.

Compliance Review

UHCCP received a "full compliance" designation for Subcontracting, Member Services and Education, and Quality Management, and a "substantial compliance" designation for Grievances and Appeals and Utilization Management.

- Of the 15 standards/substandards reviewed for Grievances and Appeals, 14 were fully compliant and one (1) was substantially compliant. The following details findings from the review of this substantially compliant standard:
    o One (1) of 10 appeal files required an extension, however there was no evidence of a phone call to the member to give verbal notice of the delay.

- Of the 29 standards/substandards reviewed for Utilization Management, 26 were fully compliant and three (3) were substantially compliant. The following details findings from the review of these substantially compliant standards:
    o Inter-rater reliability is conducted once a year for staff that makes authorization decisions. A report that details mechanisms to ensure consistent application of review criteria for authorization decisions was not made available during the 2017 compliance review.
    o UHCCP submitted evidence of utilization by provider and health centers, however demographic stratification was only apparent by age. Reports exist for both physical health and behavioral health services, wherein members are reviewed by geographic location and then additional demographics are available for drill-down, per onsite discussion.
    o One (1) of 10 UM denial files reviewed did not include evidence that the member received a notification letter, although the provider letter was sent within the appropriate timeframe.

In the domain of quality, IPRO recommends that UHCCP:

- Provide members with verbal notice of delay when the timeframe for appeal resolution is extended.
- Provide a report that details mechanisms to ensure consistent application for review criteria for authorization decisions during each annual compliance audit.
- Provide utilization reports that include demographic stratification by race, ethnicity and gender during each annual compliance audit.

- Ensure that UM denial files include evidence of a written notice of action provided to the member.

Timeliness
The timeliness domain includes findings from two (2) of the seven (7) compliance domains; Utilization Management and Grievances and Appeals. All UM and Grievance and Appeal files reviewed demonstrated that elements were completed on time.

Access
The access domain includes findings from two (2) of the seven (7) compliance domains; Care Management and Provider Network.

UHCCP received a "substantial compliance" designation for Care Management, and a "full compliance" designation for Provider Network.

- Of the 43 standards that were reviewed for Care Management, 39 were fully compliant and four (4) were substantially compliant. The following details findings from the review of these substantially compliant standards:
  - Training documents provided to care management staff do not address barriers members may experience in making and keeping appointments.
  - UHCCP has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.
  - A total of 20 care management files were reviewed; one (1) of 20 files did not include a risk stratification level. Of the 18 files that included an individual plan of care, one (1) file did not demonstrate monitoring of progress towards goals.

In the domain of access, IPRO recommends that UHCCP:

- Develop staff training specific to barriers members may experience in making and keeping appointments. UHCCP may consider using their web-based tutorial, LearnSource.
- Partner directly with provider practices that demonstrate higher medication adherence rate.
Ensure that all file documentation includes a risk stratification level, and evidence of monitoring of progress towards individualized care plan goals.

WellCare Health Plan of Nebraska
Quality
The quality domain encompasses PIP activities and findings from five (5) of the seven (7) compliance domains (Member Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management).

PIPs
In 2017, WellCare submitted proposals for three PIP topics: Improving Follow-up After ED Visit for Mental Illness or Substance Use Disorder, Initiation of 17p in Pregnant Women, and Tdap Vaccination for Pregnant women. The goal of the ED PIP is to increase 7-day follow-up after an ED visit for mental illness from a baseline rate of 34.5% to a rate of 41.8% and to increase the 30-day follow-up rate from a baseline of 58.1% to a rate of 66.5%. Additionally, the MCO's goal is to increase the 7-day follow-up after an ED visit for Alcohol and Other Substance Use from a baseline rate of 6.2% to a rate of 18.2% and increase the 30-day follow-up rate from a baseline rate of 9.2% to a rate of 21.2% (note these rates reflect the 18 and older subgroup). For the 13-17 year old subgroup, the MCO's goal is to increase the 7-day follow-up after an ED visit for Alcohol and Other Substance Use from a baseline rate of 4.6% to a rate of 16.4% and increase the 30-day follow-up rate from a baseline rate of 13.4% to a rate of 25.0%. For the 17p PIP, the MCO's goal is to increase the proportion of members who received 17p from a baseline rate of 24.0% to a final rate of 29.5%. For the Tdap in Pregnant Women PIP, WellCare's baseline rate for the percentage of pregnant women receiving Tdap at the optimal gestational age is 12.97%. The MCO hopes to increase this rate to a final rate of 15.95%. The baseline rate for pregnant women receiving Tdap at any time during pregnancy is notably higher, at 64.3% and the MCO hopes to increase this rate to 79.1%. As a means to continually monitor MCO PIP performance, Quality Improvement Committee

meetings take place once a month, wherein the NE MCOs and DHHS Division of Medicaid Long Term Care meet to discuss PIP progress and barriers to-date.

Compliance Review
WellCare received a "substantial compliance" designation for Member Services and Education, Quality Management, Utilization Management, and Grievances and Appeals. The MCO received a "minimal compliance" designation for Subcontracting.

- Of the 10 standards/substandards reviewed for Member Services and Education, eight (8) were fully compliant, and two were substantially compliant. The following details findings from the review of the substantially compliant standards:
    o WellCare provided two reports onsite which provided data for utilization of phone line and in-person translation for different languages, including Native American languages. However, the number of members with Native American languages as their primary language or the number of providers with these languages was not listed in these files (Spanish, Arabic, Vietnamese, Russian, and French break-downs are provided); therefore, network adequacy is difficult to determine from these reports.
    o Onsite, WellCare demonstrated that the Member Handbook is accessible on their website in English. The MCO indicated that the Handbook in Spanish is currently being developed and should be online soon.

- For Quality Management, a total of 24 standards/substandards were reviewed. Twenty-two (22) standards were fully compliant, and two (2) were substantially compliant. The following details findings from the review of substantially compliant standards:
    o There is an opportunity to present information about the QAPI program to the broader WellCare membership by incorporating it into the Member Handbook or on the MCO website.
    o WellCare submitted the MAC report to MLTC after the first 6 months of operation. It was not able to be determined from this report which individuals were members of WellCare, versus which were staff. Further, member addresses were not provided in this report, per contract requirements.

- Of the 29 standards/substandards reviewed for Utilization Management (UM), 26 were fully compliant and three (3) were substantially compliant. One (1) of these standards relates to quality. The following details findings from the review of this substantially compliant standard:
    o Seven (7) out of 10 UM files that were reviewed met the requirement for written notice to members to explain the member's right to a State Fair Hearing.

- Of the 15 standards/substandards that were reviewed for Grievances and Appeals, 11 standards/substandards were fully compliant, and four (4) were substantially compliant. The following details findings from the review of these substantially compliant standards:
    o Eight (8) of 10 appeal files contained the acknowledgement letters. Acknowledgement letters were not found in three (3) grievance files.
    o Ten (10) appeal files were reviewed. Of the 10 files, seven (7) were standard appeals. Zero (0) of seven (7) standard appeal files contained evidence that the member was given the opportunity to present evidence in person as well as in writing.
    o One (1) of 10 files did not contain the results and date of the appeal resolution.
    o Three (3) of 10 appeals files were expedited appeals. One of these files met the requirement that the member must be informed of the limited time available to present evidence and allegations of fact or law for an expedited appeal.

- Of the four (4) standards/substandards reviewed for Subcontracting, one (1) standard/substandard was substantially compliant and three (3) were minimally compliant. The following details findings from the review of these substantially and minimally compliant standards:
    Substantially Compliant Standard

- o Of the 39 subcontractors reviewed, all 39 had written contracts that were provided for review by the MCO. Thirty eight (38) contained appropriate scopes of work. Thirty eight (38) of the 39 contained the appropriate provisions for revocation or termination due to performance. One (1) subcontractor, Advanced Medical Review (AMR), did not appear to have a contract that contained a clear scope of work and clear reporting requirements and frequency.

Minimally Compliant Standards
- o Four (4) of the 39 contracts under review for the period had initial effective dates of 1/1/17 or later and therefore evidence of a pre-delegation evaluation was expected. One of the four is the MCO's own Third Party Administrator, Comprehensive Health Management and there would not be a pre-delegation review because of the affiliated nature of the two entities and because many of the subcontractor agreements are in the name of Comprehensive health. Of the three remaining subcontractors, one had evidence of a pre-delegation audit by the MCO, and two (Amenity Consulting and Gold Group Enterprise) did not.
- o Of the 39 subcontractors, four would not have been expected to have evaluations either because they are contracts entered into less than one year earlier. Evidence of formal evaluation of the subcontractor's performance and/or ongoing monitoring and analysis of the subcontractor was only present for 10 of the remaining 35 cases reviewed.
- o Five (5) of the 10 subcontractors that had evidence of formal review by the MCO contained deficiencies that required remediation. All had communication from the MCO in regards to areas of improvement or corrective action plans. Since only 10 subcontractors received proper monitoring, it is difficult to fully assess compliance with this specific element.

In the domain of quality, IPRO recommends that WellCare:

- Track and measure I/T/U provider adequacy to ensure timely access for eligible members.
- Make the Spanish version of the Member Handbook available online to members.
- Include information about WellCare's QAPI program in the Member Handbook and/or the MCO website.
- Submit the MAC report to MLTC which clearly differentiates between WellCare members and staff, and also includes the addresses of members, per the contract requirement.
- Provide a written notice of action to members which includes notice of the member's right to request a State Fair Hearing.
- Include acknowledgment letters in all grievance files.
- In the case of standard appeals, all files should show evidence that the member was given the opportunity to present evidence in person as well as in writing.
- Ensure that all appeals files contain results and date of the appeal resolution.
- In the case of expedited appeals, ensure that all files contain language informing the member of the limited time available to present evidence and allegations, in person or in writing.
- Consider issuing an addendum to the AMR contract that clearly delineates the specific activities delegated to the subcontractor, as well as all required reporting and schedule of report deliverables expected from the subcontractor. The MCO could also consider an internal quality review of all subcontractors to ensure they contain all elements required by the master contract between the MCO and the state.
- Provide a clear narrative to guide the EQRO in the case of name changes for any of the subcontractors.
- Submit documentation pertaining to pre-delegation review within the case file for each subcontractor within the review period.
- Consider having the Delegation Oversight Committee perform an internal review of process and procedures as well as an internal audit of all existing subcontractors to ensure compliance with the contractual responsibilities. WellCare should consider establishing a single scorecard to capture all monitoring of subcontractor performance against Service Level Agreements with details of follow up on any deficiencies.
- Consider changes to their Delegation Oversight Procedure to designate a single staff person within the Nebraska team that will be responsible for following up with CAPS and reporting back to the Delegation Oversight Committee

Timeliness

The timeliness domain includes findings from two (2) of the seven (7) compliance domains; Utilization Management and Grievances and Appeals. All Grievance and Appeal files reviewed demonstrated that elements within the Grievance System were completed on time. For Utilization Management, there were two elements that were not completed on time.

- Of the 29 standards/substandards reviewed for Utilization Management, 26 were fully compliant and three (3) were substantially compliant. Two (2) of these standards relate to timeliness. The following details findings from the review of these substantially compliant standards:
  - o Nine (9) of 10 UM files met the timeliness standard for the MCO giving the member written notice of any action within the required timeframe. One (1) file demonstrated that the request for service was received 5/23/17 and the decision to deny was made 21 days later on 6/13/17. There is no mention in this file that an extension was made, and thus this file did not meet the timeliness standard.
  - o Nine (9) of 10 UM files reviewed met the timeliness standard for the MCO giving the member notice as expeditiously as the member's health condition requires.

In the domain of timeliness, IPRO recommends that WellCare:

- Provide a written notice of action to members within the specified timeframes.

Access
The access domain includes findings from two (2) of the seven (7) compliance tools; Care Management and Provider Network. WellCare received a "substantial compliance" designation for Care Management and Provider Network, and a "minimal compliance" designation for Subcontracting.

- For Care Management, 43 standards/substandards were reviewed. Forty (40) standards/substandards were fully compliant, and three (3) were substantially compliant. The following details findings from the review of these substantially compliant standards:
  - o Eight (8) of 20 care management files reviewed included a risk stratification level. For the eight files, the risk stratification level was not documented in most of the files presented. The MCO produced a separate listing of this information. Twelve files were not applicable.
  - o The MCO has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.
  - o WellCare provided staff training documents in wherein barriers to accessing treatment, such as transportation are addressed. The Case Management Program Description included case manager assistance with scheduling appointments but does not address barriers to making and keeping appointments.

- Of the 27 standards/substandards reviewed for Provider Network, 26 were fully compliant, and one (1) was substantially compliant. The following details findings from the review of the substantially compliant standard:
  - o WellCare submitted its Geo Access Q2 report. Results of the report indicated that access was below 60% across facilities and specialties in frontier regions, and between 60% and 80% in facilities and specialties in the rural and frontier regions.

In the domain of Access, IPRO recommends that WellCare:

- Ensure that all care management files include the assigned risk stratification level.
- Identify and partner with practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.
- Develop staff training specific to barriers members may experience in making and keeping appointments.
- Continue its efforts to increase adequacy in Frontier areas. WellCare should work with MLTC to address gaps in adequacy.

Background

Nebraska Medicaid Managed Care Program: Heritage Health

The State of Nebraska's Medicaid Program is administered through the Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care. The Medicaid program provides health care coverage for approximately 230,000 individuals.

Managed care was developed to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health care services in a cost effective manner. This program has steadily evolved since 1995, from an initial program that provided physical health benefits in three counties, to the current one that provides a full-risk, capitated Medicaid managed care program for physical health (PH), behavioral health (BH), and pharmacy services statewide.

The Nebraska Medicaid Managed Care (MMC) Program, formerly referred to as the Nebraska Health Connection (NHC), was implemented in July 1995 with two separate 1915(b) waivers: one for PH and one for mental health and substance use disorders (SUDs), with full-risk BH managed care effective September, 2013. In October, 2015, following a request for proposal (RFP) for their new integrated MMC Program, referred to as Heritage Health, NE DHHS contracted with three managed care organizations (MCOs) to each provide physical health care, behavioral health care, and pharmacy services for their Medicaid and CHIP enrollees, beginning January 1, 2017. Notable changes associated with the implementation of this program include the integration of physical and behavioral health care through three MCO contracts for all 93 counties in the state of Nebraska (see **Table 1**); inclusion of pharmacy services in the core benefit package and the MCO capitation rate; inclusion of the aged, blind and disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services; and the expansion of enrollment broker services to complete the process of member enrollment.

Table 1: Nebraska MCOs and Counties

MCOs	Counties
• Nebraska Total Care • UnitedHealthcare Community Plan • WellCare	Adams, Antelope, Arthur, Banner, Blaine, Body, Boone, Box Butte, Brown, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Sarpy, Saunders, Seward, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler and York

Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.
2. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability.
3. Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population.
4. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP).
5. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.
6. Medicaid beneficiaries who participate in a HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act.
7. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).
8. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined.
9. Members eligible during a period of presumptive eligibility.

MLTC currently contracts with vendors to perform the following services for the Heritage Health:

1. Physical health managed care services
2. Behavioral health managed care services
3. Enrollment broker services
4. External quality review services
5. Actuarial services
6. Pharmacy benefit management services

The Managed Care program offers clients expanded choices, increased access to primary care, greater coordination and continuity of care, cost-effective quality health services and better health outcomes through effective care management.

Table 2 displays Medicaid enrollment of immediate and prospective members across the three MCOs as of December 2017.

Table 2: Medicaid Managed Care Enrollment by MCO as of December 2017

MCO	Medicaid Managed Care Enrollment
Nebraska Total Care	79,195
UnitedHealthcare Community Plan of Nebraska	79,784
WellCare Health Plan of Nebraska	80,448

Nebraska Quality Goals and Objectives

NE DHHS developed the Medicaid Managed Care Program to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost-effective to the State. The objectives of the program continue to be improved access to quality care and services, improved client satisfaction, reduction of racial and ethnic health disparities, cost reduction and the reduction/prevention of inappropriate/unnecessary utilization.

As BH services are added to the physical health delivery system under Heritage Health, goals for all members include decreased reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment.

NE DHHS also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes:

- Improve health outcomes;
- Enhance integration of services and quality of care;
- Place emphasis on person-centered care, including enhanced preventive and care management services (focusing on the early identification of members who require active care management);
- Reduce rate of costly and avoidable care;
- Improve financially sustainable system;
- Increase evidence-based treatment;
- Increase outcome-driven community-based programming and support;
- Increase coordination among service providers;
- Promote a recovery-oriented system of care; and
- Expand access to high-quality services (including hospitals, physicians, specialists, pharmacies, mental health and SUD services, federally qualified and rural health centers, and allied health providers) to meet the needs of NE's diverse clients.

The State supplies MCEs with race, ethnicity and primary language information about Medicaid enrollees that has been collected during intake and eligibility procedures. The State expects the MCE to use the information to promote delivery of services in a culturally competent manner and to reduce racial and ethnic health disparities for enrollees.

The State has had success with prenatal incentive and Emergency Room divergence programs. Building on these successes, and successful Performance Improvement Projects carried out by MCEs, the State hopes to continue improving clinical and non-clinical care aspects with proactive and effective programming.

External Quality Review Activities

During the past year, IPRO conducted a compliance monitoring site visit and validation of performance improvement projects. Each activity was conducted in accordance with CMS protocols for determining compliance with Medicaid Managed Care regulations. Details of how these activities were conducted are described in **Appendices A and B** address:

- Objectives for conducting the activity
- Technical methods of data collection
- Descriptions of data obtained
- Data aggregation and analysis

Conclusions drawn from the data and recommendations related to access, timeliness and quality are presented in the Executive Summary section of this report.

Corporate Profiles

Three (3) MCOs comprised Nebraska's Medicaid managed care program during 2017:

- Nebraska Total Care (NTC) is a Medicaid MCO operated by Centene Corporation. Nebraska Total Care serves the entire state of Nebraska.
- UnitedHealthcare Community Plan of Nebraska (UHCCP) is a Medicaid MCO operated by UnitedHealthcare of the Midlands, Inc. United Healthcare Community Plan serves the entire state of Nebraska.
- WellCare of Nebraska (WellCare) is a Medicaid MCO operated by WellCare Health Plans, Inc. WellCare serves the entire state of Nebraska.

Table 3: Corporate Profiles

Profile Information	NTC	UnitedHealthcare	WellCare
Type of Organization	HMO	HMO	HMO
Year Operational	2017	Prior to 2002	2017
Total Medicaid Enrollment as of 12/2017	79,195	79,784	80,448
NCQA Medicaid Accreditation Status	Interim	Commendable	Interim
NCQA National Medicaid Ranking[1]	N/A	4.0	N/A

[1] 2017 ratings were unavailable at the time of this report. UHCCP rating is from 2016. NTC and WellCare ratings are not applicable, as these plans did not begin operation until 2017.

Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access

Introduction

This section of the report addresses the findings from the assessment of the MCOs' strengths and areas for improvement related to quality, timeliness and access. The findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Accreditation and Validation of Performance Improvement Projects).

Compliance Monitoring

This subpart of the report presents the results of the review by IPRO of the MCOs' compliance with regulatory standards and contract requirements for January 1, 2017 – August 31, 2017. The review is based on information derived from IPRO's conduct of the annual regulatory compliance review, which took place in September 2017. Elements not reviewed during the compliance audit were previously reviewed and deemed fully compliant during Readiness Review in 2016. IPRO's assessment methodology is consistent with the protocols established by CMS and is described in detail in **Appendix A**.

A description of the content evaluated under each compliance domain follows:

- Care Management—The evaluation of Care Management includes, but is not limited to, review of: policies and procedures for the MCO's care management program, health-risk assessment development and data collection, and file review of care management records.
- Provider Network—The evaluation of Provider Network includes, but is not limited to, review of: policies and procedures for confidentiality; direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity for primary care, specialists, hospital care and ancillary services; evidence of evaluation, analysis and follow-up related to program capacity monitoring; and enrollment and disenrollment and tracking of disenrollment data.
- Subcontracting—The evaluation of Subcontracting includes, but is not limited to, review of: policies and procedures for oversight of subcontractor performance, processes for identifying deficiencies and taking corrective action, and evidence of written contracts between the MCO and the subcontractor. Also reviewed are pre-delegation reports as well as reports that evidence ongoing monitoring and formal reviews of each subcontractor.
- Member Services and Education—The evaluation in this area includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, Indian Health Protections, documentation of advance medical directives and medical record keeping standards. Also reviewed are informational materials, including the Member Handbook; processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis and follow-up regarding advance medical directives.
- Quality Management—The evaluation in this area includes, but is not limited to, review of: Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs); HEDIS® Final Audit Report (not applicable for this reporting year, as HEDIS data were not yet available); documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.
- Utilization Management—The evaluation in this area includes, but is not limited to, review of: policies and procedures for UM, UM Program Description, UM Program Evaluation, UM activities, and file review of denials.
- Grievances and Appeals—The evaluation of Grievances and Appeals includes, but is not limited to, a review of: policies and procedures for grievances and appeals, file review of member grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes and staff interviews.

Table 4 displays the 2017 Compliance Review designations for each MCO.

Table 4: Summary of 2017 Compliance Review Findings (Measurement Period 1/1/17-8/31/17)

Compliance Domain	NTC	UnitedHealthcare	WellCare	Performance Domain(s)
Care Management	Substantial Compliance	Substantial Compliance	Substantial Compliance	Access
Provider Network	Substantial Compliance	Full Compliance	Substantial Compliance	Access
Subcontracting	Minimal Compliance	Full Compliance	Minimal Compliance	Quality
Member Services and Education	Substantial Compliance	Full Compliance	Substantial Compliance	Quality
Quality Management	Substantial Compliance	Full Compliance	Substantial Compliance	Quality
Utilization Management	Substantial Compliance	Substantial Compliance	Substantial Compliance	Quality and Timeliness
Grievances and Appeals	Substantial Compliance	Substantial Compliance	Substantial Compliance	Quality and Timeliness

For each MCO, a description is provided including: content reviewed, current year findings and recommendations, and MCO response and action plan. IPRO will assess the effectiveness of the MCO's actions during the next annual compliance review.

Nebraska Total Care

Care Management
The evaluation of Care Management includes, but is not limited to, review of: policies and procedures for the MCO's care management program, health-risk assessment development and data collection, and file review of care management records.

A total of 44 standards/substandards were reviewed; 40 standards/substandards were fully compliant, and four (4) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Risk stratification assignment	20 care management files were reviewed. Of the 19 applicable files, 3 did not include a risk stratification level. All care management files should include the assigned risk stratification level.	NTC agrees with findings. NTC provided staff education multiple times during start up and then additional training based on internal audit findings. Additionally the expectation is reinforced during team meetings throughout the year.
Continuity of care that includes collaboration and communication with other providers	Of the 20 files reviewed, 5 provided evidence of collaboration, 1 file did not provide evidence of collaboration, and 14 files were not applicable. As appropriate to the member's needs, evidence of collaboration and communication with other providers should be documented in the care management file	NTC agrees with these findings. NTC provided staff education multiple times during start up and then additional training based on internal audit findings. Additionally the expectation is reinforced during team meetings throughout the year.
Partner with provider practices having higher	The MCO has not yet identified provider practices having higher medication	NTC agrees with the findings. NTC will work with our pharmacy vendor and data

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates	adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. The MCO should identify and partner with practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.	analytic to identify the two groups based on the drug utilization rates and then strategies used for successful adherence.
Educate staff about barriers members may experience in making and keeping appointments	The staff training documents that were provided do not address barriers members may experience in making and keeping appointments. NTC should develop staff training specific to barriers members may experience in making and keeping appointments.	NTC agrees with the findings. NTC is evaluating the training materials and we have found that the materials address barriers members experience and will develop specific education information on keeping appointments.

Provider Network

The evaluation of Provider Network includes, but is not limited to, review of: policies and procedures for confidentiality; direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity for primary care, specialists, hospital care and ancillary services; evidence of evaluation, analysis and follow-up related to program capacity monitoring; and enrollment and disenrollment and tracking of disenrollment data.

A total of 27 standards/substandards were reviewed; 24 were fully compliant, two (2) were substantially compliant, and one (1) was minimally compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type	Onsite it was discussed that case management logs "no shows" in its records. The provider network department does not monitor "no show" rates. The MCO should have a process in place to monitor and reduce appointment "no show" rates by provider and service type.	NTC agrees with these findings and it is developing a process to appropriately monitor "no show" rates by provider and service type.
The MCO must monitor the practice of placing members who seek any covered services on waiting lists.	The provider network department does not monitor the practice of placing members who seek any covered services on waiting lists. NTC should have a process in place to monitor waiting lists.	NTC agrees with these findings and it is developing a process to appropriately monitor waiting lists rates by provider and service type.

Minimally Compliant Standard	Findings and Recommendations for Improvement	NTC Response and Action Plan
Geographic Access	Access was between 70% and 80% in skilled nursing, hematology and orthopedic facilities, as well as in dermatology, gastroenterology, nephrology, pulmonary medicine, and rheumatology (all in urban regions; skilled nursing facilities located in urban, rural and frontier regions). Access was between 60% and 69% in cardiology (urban), neurology (urban, rural) and orthopedic (rural) facilities, and in the following specialties; ENT (urban), optometry (urban, rural, frontier) and urology (urban). Access was less than 60% in 6 facility types and 21 specialty types (primarily in the frontier and rural regions). There was 1 facility type that was also in the urban region (urgent care), and 10 specialties (cardiovascular surgery, dialysis center, DME, endocrinology, neurosurgery, OT, PT, podiatry, radiology and speech therapy). NTC should continue its recruiting efforts to increase adequacy in the areas lacking access. NTC should work with MLTC to	NTC agrees with the findings and will continue its efforts to strengthen the network and improve the geographical access in order to reduce gaps in adequacy.

Minimally Compliant Standard	Findings and Recommendations for Improvement	NTC Response and Action Plan
	address gaps in adequacy.	

Subcontracting

The evaluation of Subcontracting includes, but is not limited to, review of: policies and procedures for oversight of subcontractor performance, processes for identifying deficiencies and taking corrective action, and evidence of written contracts between the MCO and the subcontractor. Also reviewed are pre-delegation reports as well as reports that evidence ongoing monitoring and formal reviews of each subcontractor.

A total of three (3) standards/substandards were reviewed; one (1) was substantially compliant and two (2) were minimally compliant.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated	Of the 17 contracts reviewed, only 10 had effective dates in the review period. Nine (9) of 10 met this requirement. One (Morpace) was effective 3/6/17 however no evidence of pre-delegation evaluation was provided. NTC should ensure that pre-delegation evaluation is conducted and documented.	The 2016 audit summary for Morpace was added to the IPRO FTP. This should meet the requirement of a pre-delegation evaluation for this subcontractor, however since submitted outside of the audit period, will be considered for the 2018 compliance audit.

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review	Ten (10) out of 17 subcontractors met this requirement. There was no evidence provided of ongoing monitoring for 7 subcontractors: Aarete, Altegra, Equian, Krames, Morpace, Rawlings, and SPH Analytics. NTC should put in place a control, within its Vendor Audit Program, to establish ongoing and annual reviews of all performance and share the results with the MCO's quality management committee. The MCO should establish an ongoing and annual audit schedule and convene a vendor management committee to review the results of each vendor audit.	NTC will establish ongoing and annual reviews of all subcontractors' performance and share results at NTC's quarterly Quality Management Committee meetings. The final report at the end of each year will capture the subcontractors' performance for each month. NTC will maintain an annual audit schedule and convene a Vendor Management Committee to meet annually to review the results of each vendor audit.
If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action	Ten (10) out of 17 met this requirement. Because the MCO did not provide evidence of any monitoring for 7 subcontractors (listed above), it was impossible to tell if any of those would have contained corrective action plans and effective follow-up. The MCO should	NTC will establish ongoing and annual reviews of all subcontractors' performance and share results at NTC's quarterly Quality Management Committee meetings. The final report at the end of each year will capture the subcontractors' performance for each

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
	put in place a control, within its Vendor Audit Program, to establish ongoing and annual reviews of all performance and share the results with the MCO's quality management committee. The MCO should establish an annual audit schedule and convene a vendor management committee to review the results of each vendor audit.	month. NTC will maintain an annual audit schedule and convene a Vendor Management Committee annually to review the results of each vendor audit.

Member Services and Education

The evaluation in this area includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, Indian Health Protections, documentation of advance medical directives and medical record keeping standards. Also reviewed are informational materials, including the Member Handbook; processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis and follow-up regarding advance medical directives.

A total of 10 standards/substandards were reviewed; eight (8) were fully compliant, and two (2) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Indian Health Protections	The first part of this requirement is addressed in the policy and procedure Coordination with Tribal Organization. This policy also delineates that one of the responsibilities of the tribal liaison is to inform the MCO's Networking Department about I/T/U providers who are in demand by members, but are not part of the MCO's provider network to "encourage network participation" (page 2), which pertains to item ii of this requirement. However, the MCO did not provide any reports that evidence that provider adequacy for the I/T/U providers is being tracked or measured. The MCO should track/measure I/T/U provider adequacy to ensure timely access for eligible members.	NTC is currently contracted with every I/T/U provider available in the state of Nebraska, there is no room for expansion on I/T/U provider network. NTC is at 100% network participation of eligible providers.
Written material must be available in alternative formats	This requirement is partially addressed in the Member Materials Readability and Translation Policy and Procedure pertaining to readability, oral interpretation, and language translation of member materials (pages 1 and 2). However, the policy does not include alternative formats, such as Braille, large print and audio. The Member Handbook informs the members that the handbook itself is available in large print, Braille, audio CD, and different languages on page 5. The MCO should include alternative formats in the Member Materials Readability and Translation Policy and Procedure, either in a new sentence in this policy or by citing and attaching the Language Sheet and Statement of Non-Discrimination within the policy. The MCO	The Language Sheet and Statement of Non-Discrimination will be included as an attachment to policy NE.MBRS.02.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
	may consider adding "Braille" explicitly to the Language Sheet and Statement of Non-Discrimination, since this is an alternative format that may be in demand.	

Quality Management

The evaluation in this area includes, but is not limited to, review of: Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs); HEDIS® Final Audit Report (not applicable for this reporting year, as HEDIS® data were not yet available); documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.

A total of 25 standards/substandards were reviewed; 23 were fully compliant and two (2) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually	The language for this requirement is found in NTC's QAPI Program Description, page 38. For providers, information about the QAPI program can be found on NTC's website, as well as within the Provider Manual, which also references the QAPI Committee (QAPIC), and notifies providers about the opportunity to participate in this committee. Information regarding the QAPI program can be found on the Member Resources page of the NTC website. The Member Handbook contains a broad description of the QI Program. NTC should consider including language in the Member Handbook that allows members the opportunity to ask questions about the QI Program (including the contact information for whom they can contact to ask these questions), as well as where they can find information on NTC's progress in meeting goals (i.e., NTC's website).	NTC is continuously evaluating the website and materials to ensure completeness of information. Information about the Quality Program and how to contact the plan with quality improvement opportunities has been added to the Member website and revisions to the Member Handbook will be forthcoming. Goals and progress on the goals will be added to the webpage once HEDIS rates are complete.
The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually	NTC submitted their MAC report on time to MLTC. Member addresses were not indicated within this report. The report indicates that the transition to three MCOs has been difficult for behavioral health providers. Complications could lead to providers making the decision to not accept Medicaid members and cause limited access. Provider concerns are ongoing and being addressed by NTC Provider Relations. Per regulation, member addresses should be included within the MAC report that is submitted semi-annually to MLTC.	NTC agrees with the findings and have added the member addresses to the meeting attendance and will supply with the report.

Utilization Management

The evaluation in this area includes, but is not limited to, review of: policies and procedures for UM, UM Program Description, UM Program Evaluation, UM activities, and file review of denials.

A total of 32 standards/substandards were reviewed; 29 were fully compliant and three (3) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
The MCO must have processes for each provider that monitor and report under-and over-utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age	This requirement is addressed in NTC's UM Program Description (pages 7-8) and in policy and procedure NE.UM.01.03 Monitoring Utilization (which includes reference to race, ethnicity, gender and age). Drug/age contraindication was reviewed, per report NE US MD Drug Utilization Review (RA5100). No report was submitted that evaluated demographic factors such as race, ethnicity and gender. A report demonstrating that utilization is being monitored by race, ethnicity, gender and age should be provided for the 2018 compliance audit.	NTC Agrees with the findings. NTC is developing a report for under and over utilization (including data elements of the gender/ race/ ethnicity/ and age) with data analytics.
The MCO must monitor for potential off-label drug usage	NTC did not submit any reports that evaluated for off-label drug usage, specifically, however they submitted two policies (NE PHAR 13 and CP.PMN.53), each of which contain a description of the procedures for evaluating the need for this usage among their membership. A report demonstrating that off-label drug use is being monitored should be provided for the 2018 compliance audit.	NTC Agrees with findings. NTC is working on a report specific to off-label drug use and will be reporting out to appropriate quality committees within NTC.
The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization	A report demonstrating that emergency service utilization is being monitored by provider and member was not submitted for the 2017 audit. This report should be provided for the 2018 compliance audit.	NTC is developing a utilization report of ED visits specific to provider and member.

Grievances and Appeals

The evaluation of Grievances and Appeals includes, but is not limited to, a review of: policies and procedures for grievances and appeals, file review of member grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes and staff interviews.

A total of 15 standards/substandards were reviewed; 12 were fully compliant, two (2) were substantially compliant, and one (1) was minimally compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual.	Five (5) out of 10 appeal files contained the required information. Four (4) appeal files did not meet the requirement because the individual who did the review could not be determined. The remaining one (1) appeal file was deemed not applicable because the appeal could not be processed (the member did not submit the additional information requested by the MCO). All appeal files should contain the individual who conducted the review.	NTC agrees that the internal clinical documentation that demonstrated separate reviewers was not provided. Staff is aware of the requirement and the MCO does have this documentation in their internal systems as it is part of their daily workflow. NTC will provide the completed document next audit.
Confirmation of verbal appeal inquiries in writing	Nine (9) out of 10 appeals case files were deemed not applicable because they contained inquiries in writing. The remaining one (1) appeal file did not meet the requirement because there was no evidence of the inquiry for the appeal in the file. In cases of verbal inquiries seeking to appeal, it is recommended that these inquiries are confirmed in writing.	The MCO referenced case #9 as the case in question, originally was requested as an expedited appeal (verbally). The case was ultimately withdrawn by the provider. The case IPRO was referencing as not meeting this requirement was #12.

Minimally Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
MCO must provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing	10 out of 10 appeal files did not have language specifically stating that members could present evidence in person. It is recommended that all appeal files contain the required language.	NTC notes that they do have language in their acknowledgement letter stating "Tell us if you want to appeal in person. We will set a meeting place that is close to your home." First paragraph, last sentence. This is evidence in Case #1, Case #2, Case #5, Case #6, Case #10, Case #11. Six (6) of the 10 were compliant with this requirement. NTC reviewed all cases and determined that the when an appeal request is missing information, the letter requesting this additional information needed this additional sentence. Corrections have been made.

UnitedHealthcare Community Plan of Nebraska

Care Management

The evaluation of Care Management includes, but is not limited to, review of: policies and procedures for the MCO's care management program, health-risk assessment development and data collection, and file review of care management records.

A total of 43 standards/substandards were reviewed; 39 standards/substandards were fully compliant, and four (4) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
Risk stratification	One (1) of 20 reviewed care management files did not include a risk stratification level. All care management files should include the assigned risk stratification level. It was not possible to determine whether the file that was missing a risk score was due to lack of sufficient information needed to compute this score, or failure to include this score. For members with insufficient data to compute this score, it should be noted within the chart.	If a member does not have sufficient data in their record then the score may not be calculated. The Health Plan identified members for care management according to population group/needs as well as mandates from DHHS such as fosters/wards, so some members may have been identified for care management prior to enough data accumulating for a risk score to be calculated.
Monitoring of progress towards care plan goals	Of the 18 files reviewed that included an individual plan of care, 1 file did not demonstrate monitoring of progress towards goals. It is recommended that all files demonstrate this monitoring.	UHCCP has a Plan of Care SOP which requires staff to monitor progress towards goals. The Plan of Care SOP was re-reviewed with the CM/CN team during the CM/CN staff meeting on 11/8/17 to reinforce the standard procedures for updating a member's plan of care.
Partnering with provider practices having higher medication adherence rates	UHCCP has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. Per the MCO, methods of sharing of these practices will be through outreach to providers and possible postings with the NE Pharmacist Association.	UHCCP has three processes in place to address non-adherence to medication regimens (MTM Program, DUR, and Pharmacy Director participation in NE DUR board meetings). It was recommended that the MCO partner with provider practices that demonstrate higher medication adherence rate.
Educating staff regarding barriers members experience in making and keeping appointments	Training documents provided to staff do not address barriers members may experience in making and keeping appointments. UHCCP should develop staff training specific to barriers members may experience in making and keeping appointments. UHCCP may consider using their web-based tutorial, LearnSource.	Individual training topics related to barriers members may experience in making and keeping appointments were organized into an infographic tool titled 'How to Address Doctor Appointment Barriers'. The infographic tool refers to motivational interviewing training Care Management staff receive and contains links to review materials on non-emergency medical transportation, translation services, and the nurse line. The infographic tool also provides

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
		guidance on documentation in the member record and follow up pertaining to the intervention used by the Care Manager/Navigator to address the doctor appointment barriers. Care Management staff was provided the consolidated infographic on 11/16/2017 and completed an attestation of receipt.

Provider Network

The evaluation of Provider Network includes, but is not limited to, review of: policies and procedures for confidentiality; direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity for primary care, specialists, hospital care and ancillary services; evidence of evaluation, analysis and follow-up related to program capacity monitoring; and enrollment and disenrollment and tracking of disenrollment data.

A total of 27 standards/substandards were reviewed; all were fully compliant.

Subcontracting

The evaluation of Subcontracting includes, but is not limited to, review of: policies and procedures for oversight of subcontractor performance, processes for identifying deficiencies and taking corrective action, and evidence of written contracts between the MCO and the subcontractor. Also reviewed are pre-delegation reports as well as reports that evidence ongoing monitoring and formal reviews of each subcontractor.

A total of three (3) standards/substandards were reviewed; all were fully compliant.

Member Services and Education

The evaluation in this area includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, Indian Health Protections, documentation of advance medical directives and medical record keeping standards. Also reviewed are informational materials, including the Member Handbook; processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis and follow-up regarding advance medical directives.

A total of 10 standards/substandards were reviewed; all were fully compliant.

Quality Management

The evaluation in this area includes, but is not limited to, review of: Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs); HEDIS® Final Audit Report (not applicable for this reporting year, as HEDIS data were not yet available); documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.

A total of 25 standards/substandards were reviewed; all were fully compliant.

Utilization Management

The evaluation in this area includes, but is not limited to, review of: policies and procedures for UM, UM Program Description, UM Program Evaluation, UM activities, and file review of denials.

A total of 29 standards/substandards were reviewed; 26 were fully compliant and three (3) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
Mechanisms to ensure consistent application of review criteria for authorization decisions	Inter-rater reliability is conducted once a year for staff that makes authorization decisions. A report that details mechanisms to ensure consistent application of review criteria for authorization decisions should be included for review during the 2018 compliance audit.	The authorization team is required to take courses to obtain competence to ensure consistent application of review criteria is being completed by all staff. At the time of the audit the health plan did not have access to this report known as the Inter-Reliability Report (IRR) for 2017, and the prior report was only available for 2016. This report is run between the end of October to the beginning of November of each year. The results of the 2017 MCG 21st Edition Ambulatory Care IRR, as reported by LearnSource, include both raw data and pivot tables which display the results in different ways. For confidentiality, participants are only identified by their employee ID numbers.
Processes that monitor and report over/under utilization	UHCCP submitted evidence of utilization by provider and health centers, however demographic stratification was only apparent by age. Reports exist for both physical health and behavioral health services, wherein members are reviewed by geographic location and then additional demographics are available for drill-down, per onsite discussion. Utilization reports should include demographic stratification by race, ethnicity and gender.	In order to facilitate ease of use, the drill-down demographic information available through supplemental investigation (as discussed onsite) is being moved to the initial report.
Timeframe-Notice of Action	One (1) of 10 UM files reviewed did not include evidence that the member received a letter, although the provider letter was sent within the appropriate timeframe. The MCO should ensure that UM files include evidence of a written notice of action provided to the member.	UHC provides notification of adverse determinations to members and providers, but only notifies providers of approvals.

Grievances and Appeals

The evaluation of Grievances and Appeals includes, but is not limited to, a review of: policies and procedures for grievances and appeals, file review of member grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes and staff interviews.

A total of 15 standards/substandards were reviewed; 14 standards/substandards were fully compliant, and one (1) was substantially compliant.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
Appeal Process - Resolution and Notification	One (1) of 10 reviewed appeals required an extension, however there was no evidence of a phone call to the member to give verbal notice of the delay. It was recommended that, when applicable, the member be given verbal notice of the delay. This notice should be evident in all applicable files.	UnitedHealthcare Community Plan has in place a standard operating procedure which requires resolving analysts to contact members verbally to inform them of extensions. UnitedHealthcare Community Plan reviewed the recommendation and determined that the resolving analyst that worked this particular case failed to contact the member verbally to inform them of the extension as outlined in the standard operating procedure. The standard operating procedure was reviewed to ensure appropriate direction is provided to the analysts and we verified the process is clearly documented directing the analysts to make a verbal attempt to the member and document the call. The resolving analyst that worked this case has been coached along with the rest of the team as a reminder that a verbal attempt and documentation is required on member extensions.

WellCare Health Plan of Nebraska

Care Management

The evaluation of Care Management includes, but is not limited to, review of: policies and procedures for the MCO's care management program, health-risk assessment development and data collection, and file review of care management records.

A total of 43 standards/substandards were reviewed; 40 standards/substandards were fully compliant, and three (3) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Risk stratification	Eight (8) of 20 care management files reviewed included a risk stratification level. For the eight files, the risk stratification level was not documented in most of the files presented. The MCO produced a separate listing of this information. Twelve files were not applicable. All care management files should include the assigned risk stratification level.	Each Care Manager will have 3 cases audited a month to include risk stratification. Any noted errors will be considered coaching opportunities and will be reviewed with care management leadership during monthly 1:1 sessions.
Partnering with provider practices having higher medication adherence rates	WellCare has access to the EQuIPP dashboard that provides performance tracking on pharmacy measures. The MCO has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. Per the MCO, once best practices are identified, one method for sharing these practices will be through outreach by the quality practice advisors. MCO should identify and partner with practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.	Through process of clinical leadership data review, in alignment with the current work being done by the Drug Utilization Review (DUR) process, focused drug classifications will be identified. Data from Providers and Practices whose adherence rates are meeting HEDIS® or other recognized standards will be used to create education and reporting to share with Providers and Practices not meeting standards. This information will be shared with the Providers and Practices during the encounters made with the identified practice by our Quality Practice Advisors.
Educating staff regarding barriers members experience in making and keeping appointments	WellCare provided the following staff training documents: Integrated Model of Care: Case Managing Member Guidelines; CM Audit Tool Review (& More): Nebraska Training, 9/8/17; and WellCare of Nebraska Care Management Overview. A WellCare University Transcript (training record) was also provided. Barriers to accessing treatment such as transportation are addressed. C7-CM-MD-1.2 Case Management Program Description includes case manager assistance with scheduling appointments	Training will be developed and deployed to the team to address barriers members may experience in making and keeping appointments to include transportation, language, health literacy, personal healthcare beliefs, and finding providers.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	but does not address barriers. WellCare should develop staff training specific to barriers members may experience in making and keeping appointments.	

Provider Network

The evaluation of Provider Network includes, but is not limited to, review of: policies and procedures for confidentiality; direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity for primary care, specialists, hospital care and ancillary services; evidence of evaluation, analysis and follow-up related to program capacity monitoring; and enrollment and disenrollment and tracking of disenrollment data.

A total of 27 standards/substandards were reviewed; 26 standards/substandards were fully compliant, and one was substantially compliant.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Geographic Access	WellCare submitted its Geo Access Q2 Report. Access was between 70-80 percent in FQHC and Pediatric facilities (both in rural regions), and in Dialysis Center (frontier region). Access was between 60-69 percent in the following areas: *Facilities* BH Inpatient (Frontier) BH Residential (Rural) Urgent Care (Rural) *Specialties* Occupational Therapy (Frontier) Access was less than 60 percent in the following areas: *Facilities* BH Residential (Frontier) FQHC (Frontier) Pediatrics (Frontier) Urgent Care (Frontier) *Specialties* Cardiovascular surgery (Frontier) Endocrinology (Frontier) Gastroenterology (Frontier) Infectious Disease (Frontier) Neurosurgery (Frontier) Radiology (Frontier) Rheumatology (Frontier) Speech Therapy (Frontier) WellCare should continue its efforts to increase adequacy in Frontier areas. WellCare should work with MLTC to address gaps in adequacy.	WellCare of Nebraska will continue to work with MLTC to address any gaps in adequacy. WellCare will partner with MLTC to explore alternatives, such as telehealth, to address gaps in rural/frontier areas of the state.

Subcontracting

The evaluation of Subcontracting includes, but is not limited to, review of: policies and procedures for oversight of subcontractor performance, processes for identifying deficiencies and taking corrective action, and evidence of written contracts between the MCO and the subcontractor. Also reviewed are pre-delegation reports as well as reports that evidence ongoing monitoring and formal reviews of each subcontractor.

A total of four (4) standards/substandards were reviewed; one standard/substandard was substantially compliant, and three were minimally compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Activities and reporting responsibilities are being delegated to the subcontractor by the MCO	Of the 39 subcontractors reviewed, all 39 had written contracts that were provided for review by the MCO. Thirty eight (38) contained appropriate scopes of work. Thirty eight (38) of the 39 contained the appropriate provisions for revocation or termination due to performance. One subcontractor, Advanced Medical Review (AMR), did not appear to have a contract that contained a clear scope of work and clear reporting requirements and frequency. WellCare should consider issuing an addendum to the AMR contract that clearly delineates the specific activities delegated to the subcontractor, as well as all required reporting and schedule of report deliverables expected from the subcontractor. The MCO could also consider an internal quality review of all subcontractors to ensure they contain all elements required by the master contract between the MCO and the state. The MCO should provide a clear narrative to guide the EQRO in the case of name changes for any of the subcontractors.	WellCare will issue an addendum to the AMR contract that clearly delineates the specific activities delegated to the subcontractor, as well as all required reporting and schedule of report deliverables expected from the subcontractor. Going forward, the MCO will provide a clear narrative to guide the EQRO in the case of name changes for any of the subcontractors.

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Evaluation of prospective subcontractor's ability to perform the activities to be delegated	WellCare presented a list of 43 subcontractors. During onsite discussion, it was determined that two of the subcontractors had withdrawn, two had merged and one was not in effect until after the review period. This left a universe of 39 contracts to review. Four (4) of the 39 contracts under review for the period had initial effective dates of 1/1/17 or later and therefore evidence of a pre-delegation evaluation was expected. One of the four is actually the MCO's own Third Party Administrator, Comprehensive Health Management and there would not be	WellCare will review Nebraska contractual requirements and internal policies related to when a pre-delegation review is required. When required, appropriate documentation of pre-delegation review will be submitted for future review periods. In addition, WellCare indicated that Amenity is not a delegate, and unclear if Gold Group is delegated.

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	a pre-delegation review because of the affiliated nature of the two entities and because many of the sub-contractor agreements are actually in the name of Comprehensive health. Of the three remaining subcontractors, one had evidence of a pre-delegation audit by the MCO, and two (Amenity Consulting and Gold Group Enterprise) did not. Documentation pertaining to pre-delegation review should be submitted within the case file for each subcontractor entered into within the review period.	
Monitoring of subcontractor's performance	Of the 39 subcontractors, four would not be expected to have evaluations either because they are contracts entered into less than one year earlier. Evidence of formal evaluation of the subcontractor's performance and/or ongoing monitoring and analysis of the subcontractor was only present for 10 of the remaining 35 cases reviewed. The 25 subcontractors missing evidence of ongoing monitoring and formal annual review are: Administep.com LLC Amenity Consulting Centauri Operating Company- CDR Associates, LLC Cotiviti/Connoly Concentrix CSI Southeast, Inc., d/b/a Interpretek CyraCom International, d/b/a Voiance Language Services Eliza Corporation Equian, LLC Financial Recovery Group First Recovery Group, LLC HumanArc Krames Staywell McKesson Health Solutions MTM Multilingual Group, Inc. NewGen ONEIL Digital Solution, LLC Results Technologies RR Donnelley & Sons Company Syrtis Solutions, LTD Translation Station	WellCare will review Nebraska contractual requirements and internal policies related to required oversight and monitoring of subcontractors. While WellCare has specific centralized policies and procedures for the monitoring and reviews of subcontractors who are designated as delegated entities, a different process may need to be developed for other types of subcontractors. Appropriate documentation of monitoring and reviews of subcontractors will be submitted for future review periods.

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	TransUnion Healthcare, Inc. (formerly Med Data) VRI, Valued Relationships, Inc. WellCare should consider having the Delegation Oversight Committee perform an internal review of process and procedures as well as an internal audit of all existing sub-contracts to ensure compliance with the contractual responsibilities. WellCare should consider establishing a single scorecard to capture all monitoring of subcontractor performance against Service Level Agreements with details of follow up on any deficiencies.	
Identification of deficiencies or areas for improvement, and corrective action	Five (5) of the 10 subcontractors that had evidence of formal review by the MCO contained deficiencies that required remediation. All had communication from the MCO in regards to areas of improvement or corrective action plans. Since only 10 subcontractors received proper monitoring, it is difficult to fully assess compliance with this specific element.	WellCare will review Nebraska contractual requirements and internal policies related to corrective action of subcontractors. While WellCare has specific centralized policies and procedures for monitoring and corrective action of subcontractors who are designated as delegated entities, a different process may need to be developed for other types of subcontractors. Appropriate documentation of monitoring and reviews of subcontractors will be submitted for future review periods.

Member Services and Education

The evaluation in this area includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, Indian Health Protections, documentation of advance medical directives and medical record keeping standards. Also reviewed are informational materials, including the Member Handbook; processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis and follow-up regarding advance medical directives.

A total of 10 standards/substandards were reviewed; eight (8) standards/substandards were fully compliant, and two (2) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Indian Health Protections	The MCO provided two reports, "WHP-MSE-03-NetworkAdequacyandCulturalCompetencyReport_WHP_2017_Q1" and "WHP-MSE-03-NetworkAdequacyandCulturalCompetencyReport_WHP_2017_Q2", for the onsite visit. These reports provide data for utilization of phone line and in-person translation for different languages, including Native American languages, under the "Cultural" tab. However, the number of members with Native American languages as their primary language or the number of providers with these languages are not listed in these files (Spanish, Arabic, Vietnamese, Russian, and French break-downs are provided); therefore, network adequacy is difficult to determine from these reports.	WellCare continues to track and measure utilization of I/T/U services as well as claims payment activity to ensure provider adequacy and timely access for eligible members.
	Onsite, the MCO explained that they rely on monthly claims and pharmacy claims to assess utilization of I/T/Us in their network; since I/T/Us do not have to be contracted to service members, there are no contract documents. The MCO provided two reports during the onsite visit pertaining to claims tracking: "WHP-MSE-03-IHSPharmacyReport_WHP_2017_Q2" and "WHP-MSE-03-MonthlyclaimsReport_WHP_2017_07." The former report details pharmacy claims for I/T/Us, while the latter report breaks out monthly claims by provider type, including for Indian health hospital clinics (line 54) and Tribal 638 clinics (line 55) under the "Provider Type" tab.	
	The MCO should track and measure I/T/U provider adequacy to ensure timely access for eligible members.	

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Member Handbook	This requirement is addressed in the Updates to WellCare Websites (WHP-MSE-57-C6MMO-019 Updates to the WellCare Websites_CHR_05272016) policy on pages 20 and 25. Although this policy details policy for another state, the MCO indicated that it is a corporate policy that applies to Nebraska, as well. Onsite, the MCO demonstrated that the Member Handbook is accessible on their website in English. The MCO indicated that the Handbook in Spanish is currently being developed and should be online soon. The Spanish version of the Member Handbook should be made available online to members, per a discussion that took place between MLTC and WellCare in February 2017.	WellCare agrees the Spanish Language Handbook should be made available online to members. The Spanish version of the WellCare of Nebraska Member Handbook was posted on 4/12/17, and then an updated version was posted on 10/16/17.

Quality Management

The evaluation in this area includes, but is not limited to, review of: Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs); HEDIS® Final Audit Report (not applicable for this reporting year, as HEDIS® data were not yet available); documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.

A total of 25 standards/substandards were reviewed; 22 standards/substandards were fully compliant, two were substantially compliant, and one was not applicable.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Making information available to members and providers about the QAPI program	Providers are informed about the QAPI program in the Provider Handbook. Both members and providers that are enlisted to join the QAPIC are better informed about the role of the committee and the program in general; there is an opportunity to present this information to the broader WellCare membership by incorporating it into the Member Handbook or on the MCO website. The MCO's progress in meetings its goals are assessed annually per the QAPI Program Description. The Member Handbook and/or MCO website should include information about WellCare's QAPI program.	Language to describe as well as invite members to join our QAPIC and MAC committees will be found in the Quality section of the 2018 Member handbook.
Semi-annual reporting on the activities of the MCO's Member Advisory Committee	WellCare submitted the MAC report to MLTC after the first 6 months of operation. It was not able to be determined from this report which individuals were members of WellCare, versus which were staff. Further, member addresses were not provided in this report, per contract requirements. Otherwise, all elements associated with this requirement were met within the report. The MAC report that is submitted to MLTC bi-annually should clearly differentiate between WellCare members and staff, and also include the addresses of members, per the contract requirement.	An attendance roster will be used for future meetings. The MCO provided a sample for IPRO review.

Utilization Management

The evaluation in this area includes, but is not limited to, review of: policies and procedures for UM, UM Program Description, UM Program Evaluation, UM activities, and file review of denials.

A total of 29 standards/substandards were reviewed; 26 were fully compliant and three (3) were substantially compliant.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
The MCO must give the member written notice of any action within the required timeframes for each type of action	Nine (9) of 10 files met the timeliness standard. One file contained evidence that the request for service was received 5/23/17 and the decision to deny was made 21 days later on 6/13/17. There is no mention in this file that an extension was made, and thus this file did not meet the timeliness standard. The notice of action should be provided to the member within the specified timeframes.	WellCare agrees, and has since implemented a retro review process as well as reporting to ensure TATs are met.
Written notice to members must explain the member's right to a State Fair Hearing	Seven (7) of 10 UM files reviewed met this requirement. The notice of action template appears to have changed after 4/1/17, to include notice about the member's right to obtain copy of their documents and records, as well as their right to state fair hearing. Prior to 4/1/17, the letter did not allude to member's right to request a state fair hearing, and thus the 3 files that were reviewed within this timeframe did not meet this requirement. The notice of action should include notice of the member's right to request a state fair hearing.	WellCare agrees, and the State Fair Hearing language was added.
The MCO must give notice as expeditiously as the member's health condition requires	Nine (9) of 10 UM files reviewed met the timeliness standard. Zero (0) of 10 files required an extension. The notice of action should be provided to the member within the specified timeframes.	WellCare agrees, and has since implemented a retro review process as well as reporting to ensure TATs are met.

Grievances and Appeals

The evaluation of Grievances and Appeals includes, but is not limited to, a review of: policies and procedures for grievances and appeals, file review of member grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes and staff interviews.

A total of 15 standards/substandards were reviewed; 11 standards/substandards were fully compliant, and four (4) were substantially compliant.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Acknowledgement of receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt	Eight (8) of 10 appeal files contained the acknowledgement letters. Two (2) of 10 appeals files were resolved within 10 days and thus the acknowledgement letter was not applicable. Seventeen (17) of 20 grievance files contained the required information. Acknowledgement letters were not found in 3 grievance files. WellCare responded by stating a request for information (i.e. phone number, address) would replace acknowledgement letters. WellCare received direction from the State that members whose grievance was filed between January and July 2017 did not require the full grievance response. All grievance files should contain acknowledgment letters.	WellCare agrees that grievance files should contain acknowledgement letters. Should there be a need for additional information, the State approved letter requesting additional information will be used. This letter also acknowledges the grievance, and it includes the date the grievance was received and the subject of the grievance. In addition, this letter includes language regarding information needed to process the member's grievance.
Reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing provided	Ten (10) appeal files were reviewed. Of the 10 files, 7 were standard appeals. Zero (0) of 7 standard appeal files contained evidence that the member was given the opportunity to present evidence in person as well as in writing. All standard appeal files should show evidence that the member was given the opportunity to present evidence in person as well as in writing.	The WellCare Appeals Department has several mechanisms in place to ensure members are informed of their rights and the timeline to submit additional information with their request for appeal. Members are informed that information may be provided in writing and/or in person. Currently, members are made aware of this right through the web portal and the Member Handbook. Additionally, WellCare's Customer Service Department informs members of this right when a request for appeal is received verbally. Nonetheless, to add an additional level of notification, the Appeals Acknowledgment letter has been updated to inform members of their right to submit additional information during the appeals process. In addition, the Utilization Management Notice of Adverse Benefit Determination letter has been updated to notify members of their right to submit additional information on appeal and of the limited time to submit additional information

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
		for an expedited appeal request. Both letters are now pending State submission, review and approval.
Written notice of disposition provided	One (1) of 10 files did not contain the results and date of the appeal resolution. Three (3) of 10 files contained all required elements for decisions not wholly in the member's favor. Seven (7) of 10 files were not applicable. All files should contain the results and date of the appeal resolution.	Upon the completion of an appeal, WellCare of Nebraska provides written notice of the appeals determination to the member and/or the member's representative. All appeal letters are dated; however, the appeals determination notices have been updated to list the actual date of the appeal decision.
Member must be informed of the limited time available to present evidence and allegations of fact or law in the case of an expedited appeal	This was not applicable in seven (7) of the 10 appeal files reviewed, as they were standard appeals. For the remaining three (3) files that were expedited appeals, one (1) of 3 met this requirement. All expedited appeals files should contain language informing the member of the limited time available to present evidence and allegations, in person or in writing.	The WellCare Appeals Department has several mechanisms in place to ensure members are informed of their rights and the timelines to submit additional information with their request for appeal. Members are informed that information may be provided in writing and/or in person. Currently, members are made aware of this right through the web portal and the Member Handbook. Additionally, WellCare's Customer Service Department informs members of this right when a request for appeal is received verbally. Nonetheless, to add an additional level of notification, the Appeals Acknowledgment letter has been updated to inform members of their right to submit additional information during the appeals process. In addition, the Utilization Management Notice of Adverse Benefit Determination letter has been updated to notify members of their right to submit additional information on appeal and of the limited time to submit additional information for an expedited appeal request. Both letters are now pending State submission, review and approval.

Accreditation and NCQA Ratings

NE DHHS requires that MCOs maintain NCQA accreditation for their Medicaid product line. In addition, in order to avoid duplicative review, IPRO utilizes information obtained from this private accreditation survey to assess compliance with regulatory requirements.

The NCQA began accrediting MCOs in 1991 to meet the demand for objective, standardized Plan performance information. The NCQA's MCO Accreditation is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care and timely appeals. NCQA accreditation is recognized or required by the majority of state Medicaid agencies and is utilized to ensure regulatory compliance in many states. The accreditation process is a rigorous, comprehensive and transparent evaluation process through which the quality of key systems and processes that define a MCO are assessed. Additionally, accreditation includes an evaluation of the actual results that the MCO achieves on key dimensions of care, service and efficiency. Specifically, the NCQA reviews the MCO's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections and HEDIS®/CAHPS® performance measures. NCQA accreditation provides an unbiased, third-party review to verify, score and publicly report results. The NCQA regularly revises and updates its standards to reflect clinical advances and evolving stakeholder needs. In addition, NCQA continues to raise the bar and move toward best practices, in an effort to achieve continuous improvement.

The survey process consists of on-site and off-site evaluations conducted by survey teams composed of physicians and managed care experts who interview MCO staff and review materials such as case records and meeting minutes. The findings of these evaluations are analyzed by a national oversight committee of physicians, and an accreditation level is assigned based on a MCO's compliance with the NCQA's standards and its HEDIS®/CAHPS® performance. Compliance with standards accounts for approximately 55% of the MCO's accreditation score, while performance measurement accounts for the remainder.

MCOs are scored along five (5) dimensions using star ratings between one and four stars (1 – lowest, 4 – highest)[1]:

- Access and Service: An evaluation of MCO members' access to needed care and good customer service: Are there enough primary care doctors and specialists to serve all Plan members? Do members report problems getting needed care? How well does the MCO follow-up on grievances?
- Qualified Providers: An evaluation of MCO efforts to ensure that each doctor is licensed and trained to practice medicine and that the MCO members are happy with their doctors: Does the MCO check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctors?
- Staying Healthy: An evaluation of MCO activities that help people maintain good health and avoid illness: Does the MCO give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?
- Getting Better: An evaluation of MCO activities that help people recover from illness: How does the MCO evaluate new medical procedures, drugs and devices to ensure that members have access to the most up-to-date care? Do doctors in the MCO advise members to quit smoking?
- Living with Illness: An evaluation of MCO activities that help people manage chronic illness: Does the MCO have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

Tables 5a and 5b depict the MCOs' star ratings and accreditation status.

---

[1] www.ncqa.org

Table 5a: NCQA Accreditation Ratings for Medicaid — 2016

Domain[1]	NTC	UHCCP	WellCare
Access and Service	N/A	★★★★	N/A
Qualified Providers	N/A	★★★★	N/A
Staying Healthy	N/A	★★	N/A
Getting Better	N/A	★★	N/A
Living with Illness	N/A	★★	N/A

[1] NCQA star ratings: 4 stars = highest; 1 star = lowest.
N/A: NTC and WellCare were not in operation until January 1, 2017, and thus accreditation ratings are not applicable for these MCOs. Accreditation Ratings for UHCCP reflect MY 2016, since information related to MY 2017 were not available at the time of this report.

Table 5b: NCQA Accreditation Status for Medicaid — 2017

Domain	NTC	UHCCP	WellCare
Accreditation Status	Interim	Commendable	Interim

Annually, the NCQA calculates ratings for Commercial, Medicare and Medicaid MCOs in the *Health Insurance Plan Ratings*. To be eligible for ratings, MCOs must authorize public release of their performance information and submit enough data for statistically valid analysis. In 2016, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. This information is not available for WellCare or Nebraska Total Care for the current measurement year, as these MCOs did not begin operations until January 2017. NCQA ratings for WellCare and Nebraska Total Care will be presented in 2018.

The rated categories are detailed below with UHCCP of Nebraska's rate information following in **Table 6**.

- **Consumer Satisfaction:** This category includes CAHPS® measures about consumer experience with getting care, as well as satisfaction with MCO physicians and MCO services.
- **Prevention:** Includes HEDIS® measures of how often preventive services are provided (e.g., childhood and adolescent immunizations, women's reproductive health and cancer screenings), as well as measures of children's and adolescents' access to primary and preventive visits.
- **Treatment:** Includes HEDIS® measures of how well an MCO cares for members with health problems, such as asthma, diabetes, heart disease and hypertension.

Table 6: NCQA Medicaid Ratings by Category (2016-2017) for UHCCP

Product Line	Consumer Satisfaction	Prevention	Treatment	Overall Rating
Medicaid	4.5	3.5	3.5	4.0

Assignment of HEDIS® Performance Measure Rates to Performance Domains

HEDIS performance measures required for MCO reporting per the Heritage Health Contract are represented below. These measures will be validated in 2018 for MY 2017.

The following measures are included within the Quality domain:

- *Adult BMI Assessment*
- *Human Papillomavirus Vaccine for Female Adolescents*
- *Flu Vaccination for Adults Age 18 and Older*
- *Medication Management for People with Asthma*
- *Use of Appropriate Medications for People with Asthma*
- *Antibiotic Utilization*
- *Lead Screening in Children*
- *Adolescent Immunizations*

- *Childhood Immunizations*
- *Comprehensive Diabetes Care*
- *Controlling High Blood Pressure*
- *Antidepressant Medication Management*
- *Child/Adolescent BMI Assessment*
- *Child/Adolescent Counseling for Nutrition*
- *Child/Adolescent Counseling for Physical Activity*
- *Race/Ethnicity Diversity of Membership*
- *Suicide Risk Assessment*
- *HIV Viral Load Suppression*
- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Medical Assistance With Smoking and Tobacco Use Cessation*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Plan All-Cause Readmissions*

The following measures are included within the Timeliness domain:

- *COPD Spirometry Testing*
- *Pharmacotherapy Management of COPD Exacerbation*
- *Monitoring for Patients with Persistent Medication*
- *Appropriate Treatment for Children with URI*
- *Appropriate Testing for Children with Pharyngitis*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care*
- *Adolescent Well-Care Visits*
- *Well-Child Visits in the First 15 months of Life*
- *Well-Child Visits in the third, fourth, fifth and sixth years of Life*
- *Breast Cancer Screening*
- *Chlamydia Screening*
- *Follow-up for Children Prescribed ADHD Medication*
- *Timeliness of Prenatal and Postpartum Care*
- *Frequency of ongoing prenatal care*

The following measures are included within the Access domain:

- *Children and Adolescents' Access to Primary Care Practitioners*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Follow-up After Hospitalization for Mental Illness*
- *Ambulatory Care – ED Visits/1,000 MM*

Validation of Performance Improvement Projects

Medicaid Managed Care Entities are required to develop and implement performance improvement projects (PIPs) annually to assess and improve processes of care with the desired result of improving outcomes of care. The projects are focused on behavioral and physical health care needs that reflect its demographic characteristics, prevention of disease, and the potential risk of disease. An assessment of each project is conducted upon proposal submission, and then again for interim and final re-measurement, using a tool developed by IPRO consistent with CMS EQR protocols for PIP Validation. PIP proposals were submitted on December 1, ahead of PIP implementation on January 1, 2018. Each of these PIPs is discussed separately, and each discussion includes IPRO's evaluation of the project's progress and success in achieving its goals, as well as validation results.

Nebraska Total Care

PIP: Follow-up After ED Visit for Mental Health Illness or Substance Use Disorder

When members with mental Illness or substance abuse present to the emergency department it is usually at a moment of heightened crisis. These episodes can be critical but very telling of how well a person may or may not be managing with their illnesses. It is for this reason that NTC has proposed a PIP to focus on these two populations of members that present to the ED and track follow up care for those with mental health illness (MHI) or a substance use disorder (SUD). NTC used two HEDIS® measures for this project; Follow-up After ED Visit for Mental Illness (FUM) and Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA). NTC's baseline data for FUM showed that 7 and 30 day follow-up rates of 44.71% and 64.35% respectively, while FUA baseline data reported 7 and 30 day follow up as 4.62% and 6.93% respectively (for the total population of members aged 13 years or older). NTC's FUM rates were higher when compared to the MLTC benchmark of 7 and 30 day post ED follow-up (30.3% and 53.8% respectively).

Member-specific barriers include stigma of mental health condition, the perception that substance abuse does not necessarily require medical intervention, and non-compliance with keeping follow-up appointments due to various social determinants of health (transportation, housing, community support, and access to a reliable phone for appointment reminders). Provider-specific barriers include hesitancy of ED providers to diagnose behavioral health conditions without consult, inconsistent use of billing codes, and lack of awareness related to HEDIS measures/guidelines. Plan-specific barriers include lack of behavioral health providers (especially in the rural and frontier counties), and difficulty identifying members who have had an ED visit in a timely manner. In order to overcome these barriers, NTC has implemented a series of targeted interventions, including; ED and ambulatory provider education (to lessen the stigma of mental health diagnoses, to train providers on standardized diagnostic tools and resources, and to pull claims for follow-up visits to reveal opportunities to bill for MHI/SUD as primary diagnosis); member outreach (to offer behavioral health case management support and education, and to address social determinants of health by offering free cell phones and transportation assistance); and collaboration with a state-wide health information exchange to identify ED discharges in real-time.

PIP: Initiation of 17-hydroxyprogesterone (17p) in Pregnant Women

Nebraska Total Care has proposed a PIP that focuses on pregnant women with a history of premature births. The goal of this PIP is to improve initiation of 17p in eligible pregnant women, while considering the racial disparities that are evident among the prevalence of preterm births, with the highest rate nationally among the black subpopulation. Based on data collected in Nebraska from 2012-2014, 25.2% of black women who are pregnant receive inadequate prenatal care in comparison to 11.3 percent of white women who are pregnant.

In 2016, the rate of preterm birth in Nebraska was 9.6% (March of Dimes Peristat) which was only slightly below the national average of 9.8%. According to 2016 MLTC data, 12.6% of Nebraska Medicaid Managed Care members received 17p between the recommended 16-26 weeks gestational age. Conversely, 2017 NTC data (collected from January through September) demonstrates a higher rate of eligible women receiving 17p (20.6%). NTC seeks to further improve this rate, by establishing a goal of 35% by the end of the project period in 2020.

Provider barriers include potential knowledge deficit of providers and office staff related to practice guidelines, billing/coding for 17p, MCO resources, and Makena financial resources for those members awaiting Medicaid coverage. MCO barriers include lack of awareness of pregnant members due to a decline in the submission of notice of pregnancy (NOP) forms by providers and other delays in pregnancy information (e.g., claims and/or late entry into care). Member

barriers include lack of knowledge on the prevention of preterm birth. In order to address these barriers, NTC has developed the following interventions; provider education, utilizing gap reports to target under-performing provider offices; development of educational materials using existing practice guidelines/ACOG resources; partnering with Makena to verify resources and assist with outreach; evaluate web and provider resources for CM content related to pregnancy CM; development of Healthy Babies Provider Incentive program, to promote early NOP submission and encourage initiation of 17p; develop member educational materials in collaboration with all MCOs and Department of Public Health; and target members in the NICU for education based on their risk for a subsequent preterm birth.

PIP: Tdap Vaccination in Pregnant Women
Pertussis, known commonly as whooping cough, is a respiratory disease caused by the bacterium *Bordatella pertussis.* The incidence of pertussis has gradually increased in the United States since the 1990s. NTC has proposed a PIP to reduce the rate of pertussis in women and babies by administering Tdap vaccinations to pregnant women. Vaccinating pregnant women would provide passive immunity to their unborn child. The two indicators established for this project are as follows; percent of pregnant women with a Tdap vaccination at any point during pregnancy, and the percent of women with a Tdap vaccination during the optimal time period during pregnancy (26-37 weeks gestation). January – September 2017 baseline data indicate that 53% of NTC pregnant members received the Tdap vaccination at any point during pregnancy, while 46% received the vaccine during the optimal time period. Both rates were below the MLTC 2016 benchmark rates of 61% and 49%, respectively. NTC seeks to improve their rates of Tdap vaccination among pregnant women, from 53% to 65% any time during pregnancy, and from 46.3% to 58.0% during the optimal 27-36 weeks gestation.

Provider-specific barriers include lack of knowledge related to practice guidelines related to Tdap in pregnancy and benefits to newborn lack of awareness on appropriate billing/reimbursement and coding for Tdap, and lack of defined and sustainable vaccination process in offices related to those receiving vaccine through Vaccines for Children (VFC) vs. Medicaid vaccination coverage. Member-specific barriers include lack of knowledge on benefits of Tdap vaccination during last trimester of pregnancy. To overcome barriers, NTC proposes educating members on the efficacy of the Tdap vaccination during the last trimester for the prevention of preterm birth. In terms of addressing provider barriers, NTC has created educational materials, utilizing gap reports to target providers who immunize outside of the optimal time period (or not at all). In addition, NTC has created education for providers around billing and coding processes for proper claim submissions and reimbursements, as well as the VFC Program.

UnitedHealthcare Community Plan
PIP: Follow-up After ED Visit for Mental Health Illness (MHI) or Substance Use Disorder (SUD)
UHCCP proposed a PIP to improve the rate of follow-up after ED utilization for members with a primary diagnosis of MHI or SUD. The project employs two HEDIS® measures; Follow-up After ED Visit for Mental Illness (FUM) and Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA). Analysis of UHCCP's baseline data showed 7 and 30 day follow-up rates for FUM (64.9% and 77.2%) and FUA (24.7% and 27.0%) to be markedly higher than the statewide average, however there is still room for improvement, as the MCO seeks to improve these rates over the course of this two year PIP. The PIP goals are to increase the FUM 7 and 30 day rates to 78.9%, and increase the FUA 7 and 30 day rates to 30.4% and 33.2%, respectively. It should be noted that at the time of this report, baseline data were collected from January-July 2017. Once calendar year 2017 data become available, these rates will be adjusted within the MCO's reports and analyses.

Barriers cited by UHCCP include member non-compliance with follow-up visits, social determinants of health, and non-adherence to prescribed medication. Provider-specific barriers identified include limited access to appointments 7-days post-discharge and lack of diagnosis accuracy. UHCCP proposes a variety of interventions to address these barriers, including care management (CM) contact with member post-discharge to complete provider visit verification, assess barriers to completing visits, and conduct an assessment of discharge instructions for post-ED care. UHCCP also seeks to establish a relationship with the various hospitals to replicate reports currently being piloted within Children's Hospital, which provides the MCO with real-time information pertaining to their members currently in the ED. To address social determinants of health, UHCCP is enlisting the help of community health workers to assist with arranging community resources such as substance abuse services, Medicaid and Social Security benefits, food, clothing, furniture, and transportation needs.

PIP: Initiation of 17-hydroxyprogesterone (17p) in Pregnant Women

UHCCP is targeting pregnant women with a history of spontaneous preterm birth with their PIP titled "17-hydroxyprogesterone in Pregnant Women". The MCO noted that there are higher rates of preterm birth among low-income women in Nebraska compared to middle and high income women, and an overall recurrent preterm birth rate in Nebraska of 23%. The MCO also noted that, per the 2016 Nebraska Disparities Chartbook, there are racial and ethnic disparities in the early initiation of prenatal care.

At the time of this report, UHCCP's baseline for 17p initiation (18.2%) was collected from January-June 2017, and the statewide benchmark (16.4%) was collected from January-December 2016. Once calendar year 2017 data become available, these rates will be adjusted within the MCO's reports and analyses. Based on these preliminary rates, the MCO has set out to achieve a PIP goal rate of 22.7% (4.5 percentage points above their current baseline).

Member-related barriers identified include non-compliance with prenatal visits, access to care, and social determinants of health (transportation most notably). Provider-related barriers identified include timely completion of the Obstetrical Needs Assessment Form (ONAF), pre-authorization requirement for Makena, and knowledge-deficit regarding the billing of 17p. MCO-related barriers include difficulty identifying women with a history of preterm birth.

In order to overcome these barriers, UHCCP has proposed several targeted interventions, including; utilizing maternal/child health coordinator/Healthy First Steps case management to outreach pregnant members to increase prenatal visit compliance; ONAF education for providers and staff; case management referral to housing navigator, and educating members about transportation services (Intelliride); and collaborating with provider advocate team to assist with clarifying 17p billing.

PIP: Tdap Vaccination in Pregnant Women

To reduce the rate of pertussis in new mothers and their babies, UHCCP has proposed a PIP to encourage Tdap vaccination in pregnant women. January-June 2017 baseline data indicate that 63.8% of UHCCP pregnant members received the Tdap vaccination (56.8% during the optimal 27-36 week gestation age period). These rates are slightly higher than the 2016 statewide average of 60.8% and 49.5%, for Tdap vaccination anytime during pregnancy and during the optimal time period, respectively. The MCO has a goal of 85% for Tdap at any time during pregnancy, and 75% for Tdap during the optimal time period.

Member-related barriers include resistance to immunization and non-compliance with prenatal visits. Provider-related barriers include lack of knowledge regarding benefit of Tdap immunization during pregnancy and lack of vaccine or staffing in the rural areas of Nebraska. To address these barriers, the MCO has proposed increasing member education (via educational flyer project in partnership with DHHS; UHCCP-sponsored calls through Silverlink automated calling; and a new Tdap incentive for the Baby Blocks Program). Additionally, UHCCP has proposed direct outreach to pregnant members to address member non-compliance with prenatal visits, and direct outreach to providers for education.

WellCare of Nebraska

PIP: Follow-up After Emergency Room Visit With a Diagnosis of Mental Health Illness or Substance Use Disorder

WellCare has proposed to close the gap between ED visits and follow-up care for mental health illness and substance use disorder. Specifically, the Plan would like to improve rates for the Follow-up After ED Visit for Mental Illness (FUM) and the Follow-up After an ED Visit for Alcohol and Other Substance Use (FUA) HEDIS® measures. The goal of the PIP is to increase 7-day FUM rate from a baseline of 34.5% to 41.8% and to increase the 30-day FUM rate from 58.1% to 66.5%. Additionally, the goal of this PIP is to increase the 7-day FUA rate from 6.2% to 18.2% and increase the 30-day FUA rate from 9.5% to 21.2%, for members 18 years of age and older. For the 13-17 year old subgroup, the MCO's goal is to increase the 7-day FUA rate from 4.6% to 16.4%, and increase the 30-day FUA rate from 13.04% to 25.04%. It should be noted that at the time of this report, baseline data were collected from January-July 2017. Once calendar year 2017 data become available, these rates will be adjusted within the MCO's reports and analyses.

Member-specific barriers to follow-up care after ED visits cited by WellCare are member awareness of and compliance with recommended ED follow-up guidelines and lack of community resource integration with physical and behavioral providers and utilization by members. Interventions designed to address these barriers include promoting utilization of Community Assistance Line to members and member newsletter articles which increase awareness of ED follow-up guidelines. Provider-specific barriers are provider awareness of ED utilizing members and WellCare resources and provider awareness of ED follow-up guidelines. Interventions which target provider-level barriers are review of the ED

Utilization Report with providers are regular intervals and provider education to providers on clinical practice guidelines for ED utilization management. Plan-specific barriers identified are timely identification of ED visits for SUD and mental illness and the need for additional after-hours, telephonic, and ED diversion support. Interventions which address plan-level barriers include improvement of current data streams through the implementation of Nebraska Health Information Initiative and through data exchange agreements with targeted high-volume facilities. Additionally, the MCO will promote utilization of WellCare's 24/7 Crisis Line to members and providers.

PIP: Initiation of 17 – Hydroxyprogesterone in Pregnant Women with a History of Spontaneous Preterm Birth
WellCare hopes to mitigate the incidence of spontaneous pre-term births in pregnant women through increased use of 17P during pregnancy. The performance indicator for the project is the proportion of WellCare members in the eligible population who received 17P in the measurement year. At the time of this report, the January-December 2016 MLTC benchmark rate for this indicator is 16.4%. Although WellCare's rate for the performance indicator remains above the MLTC benchmark, the MCO's goal is to increase the proportion of members who received 17P from a baseline rate of 24% to a final rate of 29.5%.

A member-related barrier cited include member adherence to 17P injections. To address this barrier, the MCO plans to provide home health services upon request when the need for home health is identified by physician referral, outreach from the history of pre-term birth query, Alere High Risk OB Care Management, and/or an Obstetric Needs Assessment Form (ONAF). Provider knowledge has been cited as a barrier related to contracted providers of WellCare. WellCare will provide provider education on indications, timing, efficacy, and availability of 17P therapy, ONAF, WellCare's process for timely authorizing and dispensing of 17P, proper billing for pharmacy coverage, coding for a history of pre-term birth, and presumptive eligibility. Identification of pregnant members has been cited as an MCO-related barrier. Interventions designed to address this barrier include identification of pregnant members by claims data, pharmacy data, history of pre-term birth query, Alere High-Risk OB Care Management, and ONAF, and outreaching all prenatal providers of potentially eligible 17P members who were identified by the history of pre-term birth query.

PIP: Tdap Immunization During Pregnancy
WellCare proposes to increase Tdap immunization rates in the membership population of pregnant women to decrease infant mortality, as pertussis is a preventable disease through immunization during the optimal timeframe of administration between 27-36 weeks gestation. The performance indicators to measure the success of the project are (1) the percent of pregnant women who received Tdap immunization at any point during pregnancy, and (2) the percent of pregnant women who received Tdap immunization during the optimal 27-36 week gestational age period. WellCare hopes to increase the rate for indicator one from a baseline rate of 64.3% to a final rate of 79.1% by the end of the PIP. For indicator 2, WellCare's goal is to increase the baseline rate of 12.97% to a final goal rate of 15.95%. Of note, the MLTC benchmark rate for indicator 1 is 60.83% and 49.49% for indicator 2.

Member-level barriers include member lack of knowledge/health literacy concerning Tdap during pregnancy and prevention of pertussis. To address this barrier, WellCare will collaborate with Nebraska public health for educational materials to be distributed state-wide. Provider awareness of current WellCare clinical recommendations of Tdap during pregnancy and prevention of pertussis has been cited as a provider-related barrier. To mitigate this barrier, WellCare's Quality Practice Advisors (QPAs) will educate providers concerning Tdap administration during pregnancy, prevention of pertussis, and HEDIS® immunization and PPC measures. MCO-level barriers include claim and encounter data completeness substantiating Tdap administration. WellCare QPAs will educate providers on NCQA HEDIS® Aditor-approved Pseudoclaim database process and health information data site capabilities.

Nebraska Quality Strategy

Nebraska's Quality Strategy (originally approved in July 2003) was last re-written in 2017 to address the change to an integrated managed care program (Heritage Health) that covers physical health care, behavioral health care, and pharmacy benefits. As part of its Quality Strategy, the State requires that all Managed Care Entities have methods to determine the quality and appropriateness of care for all Medicaid enrollees under the Nebraska Medicaid contracts.

DHHS assesses the quality and appropriateness of care through multiple processes that comprise a comprehensive system of oversight:

- Quarterly reporting of provider accessibility analyses, monitoring of timely access standards, grievances and appeals process compliance, UM monitoring, monitoring results of service verification, monitoring out of network referrals and case management results.
- Annual reporting of DHHS-selected performance measure results and trends related to quality of care, service utilization and member and provider satisfaction.
- Annual reporting of PIP data and results.
- Annual, external independent reviews of the quality outcomes, timeliness of and access to, the services covered by the MCE.
- Annual state-conducted onsite operational reviews that include validation of reports and data previously submitted by the MCE and in-depth review of areas that have been identified as potentially problematic.
- DHHS requires MCEs to attend quarterly Quality Management Committee meetings, during which data and information designed to analyze the objectives of the Quality Strategy are reviewed. The Quality Management Committee recommends actions to improve quality of care, access, utilization, and client satisfaction, and to review the results of the PIPs and recommend future PIP topics. The Quality Management Committee also reviews the state's overall Quality Strategy and makes recommendations for improvement.

The full version of Nebraska's Quality Strategy can be found on the Department of Health and Human Services website: http://dhhs.ne.gov/medicaid/Documents/Quality Strategy for Heritage Health and the Medicaid Dental Benefit Program 2017.pdf.

Efforts to Reduce Healthcare Disparities

As part of this year's technical report, IPRO discussed current efforts to reduce healthcare disparities with the state and MCOs. A summary of the information provided follows.

The objectives of the Nebraska Medicaid Managed Care Program are to improve access to quality care and services, improve client satisfaction, reduce racial and ethnic health disparities and reduce/prevent inappropriate/unnecessary utilization. Per the DHHS Division of Medicaid and Long Term Care's Quality Strategy, DHHS requires MCEs to maintain an information system that includes the capability to collect data on client and provider characteristics, identify methods to assess disparities in treatment among disparate races and ethnic groups, and to correct those disparities. MCEs have incorporated these data into PIPs by stratifying results according to these characteristics to assess health care disparities and launching a Health Care Equity Collaborative.

Further, DHHS has specific Cultural Competency Access standards, which include client access to more than one (1) primary care physician (PCP) that is multi-lingual and culturally diverse. MCEs must have a searchable database that includes network providers and facilities with information regarding race/ethnicity and languages. MCEs assess the cultural, ethnic, racial, and linguistic composition of their networks against the needs and preferences of enrollees and include provider search options for language spoken and ethnicity.

DHHS currently provides client data related to race, ethnicity and primary language through the monthly eligibility file transmitted to the MCEs. It is expected that the MCEs will use this data to promote delivery of services in a culturally competent manner and to reduce racial and ethnic health disparities for enrollees.

A comprehensive description of DHHS efforts to reduce healthcare disparities can be found in their Quality Strategy (link provided in the previous section, titled "Nebraska Quality Strategy").

Nebraska Total Care

In 2017 NTC evaluated member data, and established infrastructure to meet the future needs of members. For 2018, the MCO will be focusing on further data collection related to health disparities data analysis, development and implementation of potential initiatives based on a subpopulation on one of the health plan's costliest members, Neonatal Intensive Care (NICU) babies. This evaluation on health disparities will also support the collaborative PIP related to 17-hydroxyprogeterone during the recommended intervention time of 16-26 weeks gestation and Tdap immunization during pregnancy.

Racial disparities are evident among the prevalence of preterm births, with the highest rate nationally among the black subpopulation (20.5% for preterm, 4.1% for very preterm). In Nebraska, according to 2011 March of Dimes data, the black population makes up 44.1 percent of the Medicaid coverage before pregnancy. Data collected from 2012 -2014 in Nebraska demonstrate that of the over 25.2% of the black population that is pregnant, 25.2% receive inadequate prenatal care in comparison to 11.3% of whites. Prematurity of the black population is at 12.7%, highest of all race/ethnic groups in comparison to 8.8% of the white population group (March of Dimes Peristats, 2017).

Current data collected by the MCO on race are self-disclosed data by the member. This is obtained through the Notification of Pregnancy (NOP) form that is submitted either by the member and / or the provider. These data are then inputted into the electronic data warehouse for data analytics.

Based on reportable NOP data, the Caucasian population submitted the majority of the NOP's at 224 with Black /African American at 46 submissions. Goal for 2018 is to see more robust submission of NOP forms. NTC has state approval for a provider incentive for NOP submissions with a goal of early submissions in the first trimester.
NTC is currently collecting data related risk scores for pregnant members, as well as care coordination needs identified by members, stratified by race/ethnicity. Based on the number of NOPs submitted, there was a statistically significant difference between the percent of African American and Native American populations (inclusive of other ethnic subpopulations) in the high risk category compared with other ethnic groups. As additional racial and disparities data

becomes available, more defined reports can be developed with relevant action plans that relate to the social determinants but also that may impact the two PIP projects related to pregnancy.

United Healthcare Community Plan of Nebraska

UHCCP works to support the objectives of the Nebraska Medicaid and Long-Term Care – Heritage Health Program and conducts an annual analysis to ensure that its network has sufficient numbers and types of practitioners (clinicians) and providers (facilities) to serve enrollees. The analysis assesses the geographic and numeric availability of practitioners and providers against UHCCP availability standards, identifies and prioritizes opportunities for improvement, takes action to address opportunities and evaluates the effectiveness of actions taken. To reduce racial and ethnic health disparities, the MCO assesses the cultural, ethnic, racial, and linguistic composition of the network against the needs and preferences of enrollees and adjust the availability of practitioners within the network, as necessary. The MCO performs analysis on accessibility to tribal providers to ensure Native American members have direct access to tribal providers. The MCO is contracted with all tribal providers in the service area as well as all Federally Qualified Health Centers.

Data to Assess Ethnic, Racial, and Cultural and linguistic Availability
- The annual member satisfaction survey using CAHPS® is conducted to monitor the satisfaction of members with ethnic, racial, cultural and linguistic practitioners.
- Member and provider appeals are tracked and trended quarterly and used by staff to identify and address incidences or trends with member access to a multicultural provider.
  - UHCCP produces a report quarterly that reviews the number of members who have indicated that English is not their primary language compared to the number of providers that have indicated they speak that language.   The report is used to identify network needs for cultural and linguistic availability by county.
  - UHCCP uses the results from data analysis to develop action plans if necessary to improve access ethnic, racial, cultural and linguistic availability. These reports are taken to Quality Committees for review and input. In addition to monitoring their network, the MCO also utilizes a "language line" for interpreter services when interacting with members.
  - UHCCP's philosophy is to help ensure culturally competent care providers emphasize a "whole member" approach, taking into account the member's environment, background and culture. The MCO is also committed to disability competency in which individuals and systems provide services effectively to people with various physical and behavioral disabilities. To support providers to be culturally competent, UHCCP maintains a cultural competency library on their website for providers to be informed and find additional resources on cultural competency.
  - UHCCP supports Accountable Care Organizations (ACOs) in Nebraska. As Medicaid ACO activity in Nebraska increases, the MCO's ACO core team will be sharing the following actionable information to the provider on their patient population: patient rosters that inform the clinical team of the health status, chronic conditions, and utilization of health care services of their members, review of high risk members to ensure that regular visits are occurring and that the member has a relationship with the primary care physician.

Training Staff on Cultural Competency
- UHCCP conducts ongoing training for all staff, including information on the very latest in program updates, related changes and requirements. Ongoing training also addresses cultural competency and special health care coordination needs of Nebraska members, including: cultural awareness and understanding of health disparities among cultural groups; treating each person with dignity and respect; communication protocols for members with limited English proficiency; and barriers facing individuals with special health care needs.
- UHCCP collaborates with the Refugee Task Force Committee and the State Tribal Nations on education and training to continue fostering cultural awareness and understanding of any health care needs. In 2017, UHCCP prepared two educational modules, "Strengthening Relationships with American Indians and Alaska Natives" and a Lunch and Learn that provided information on language and culture.
- UHCCP's Member Services advocates are trained to understand and anticipate members' unique needs, including cultural competency, to promote sensitivity to improve the member experience. Training in motivational interviewing helps to promote member engagement and information gathering (such as pregnancy, barriers to care, and unmet needs) to help the MCO provide personalized services.

Reducing Barriers to Care

To assess disparities in treatment among members, address issues of population health and correct those disparities, UHCCP uses technology to ensure that high quality, timely and appropriate health care is available to all members and clinical risk stratification tool confirm that members are receiving optimal care. UHCCP's cultural competency strategy includes the following Heritage Health initiatives:

- **Initiative One:** Provide provider cultural competency training
  UHCCP provides links to providers for abstracts of peer-reviewed journal articles relevant to patient health literacy and the promotion of a health literate society. Additional cultural sensitivity and health literacy materials are available to providers at unitedhealthcareonline.com. This training provides easy, accessible, user-friendly tools that can improve the cultural competency of physicians and other health care professionals.

- **Initiative Two:** Training/claims lab for Indian Health Services (IHS) billing and claims
  Nebraska is home to four Native American tribes with most of this population residing in three counties: Thurston, Douglas and Lancaster. To monitor integration and build our relationship and understanding with tribal liaisons, we provide training for staff related to billing, coding, claims and other operational issues.

- **Initiative Three:** Develop and establish a Nebraska Health Equity Committee
  UHCCP will establish an ad hoc Health Equity Committee, a joint effort between state and local agencies, community-based organizations, private and public health services organization providers and other stakeholders. The goal is to develop and evaluate culturally appropriate programs, policies and services aimed at improving health equity and eliminating health disparities. The ad hoc committee will advise the health plan on its Health Disparities Plan.

- **Initiative Four:** Implemented a Health Disparities Action Plan
  UHCCP has a Health Disparities Action Plan which supports efforts to reduce health disparities for members and addresses disparities associated with age, gender, address, race & ethnicity, language and disability. The main goals are to improve the quality of health of consumers and communities and to embrace diversity by creating a continuum of culturally sensitive initiatives that promote health and prevent avoidable health care cost. The disparities workgroup meets on a regular basis to update the action plan and interventions. The group is a cross-functional group consisting of clinical, network, operations, data and informatics, customer service and marketing departments. This group studies multicultural population stratification using HEDIS® and claims-based data and develops interventions based upon the understanding of current gaps in health and health care in Nebraska to create an action plan focused on utilizing culturally sensitive methods to close gaps in care.

- **Initiative Five:** Continue to foster trust and relationships with key vulnerable populations
  UHCCP will continue its community engagement with organizations that advocate for the most vulnerable populations, such as individuals with special needs. This includes organizations such as Arc of Nebraska, Disabilities Rights, and others. We will foster trust and relationships by hosting Lunch N Learns with key tribal community clinicians and participate in community events such as The Good Life in My Moccasins, an outdoor family fair with the goal of connecting Native American families and low-income communities to health care services. The MCO has also built relationships with refugee coalition organizations and the Mexican Consulate to better support member populations. In 2017, 252 community events were hosted across the state of Nebraska.

- **Initiative Six:** Continue the approach for community-based services planning
  Community-based services continue to stress importance and ties to local organizations and members of the communities. Within the community-based services plan, we have a tribal liaison that provides member education on benefit services and coordinating community events.

- **Initiative Seven:** Member Advisory Committee (National and Local)
  UnitedHealthcare National Advisory Board demonstrates our commitment to a member-centric culture. The National Advisory Board improves the way we deliver services to dual-eligible individuals, including seniors and persons with disabilities. The National Advisory Board serves as an independent advisory council that provides input to UHCCP with actively engaging members, providers, advocacy groups and other stakeholders in the design and delivery system supporting individuals with special health care needs. To improve the way we deliver services, the National Advisory Board has initiated innovative training strategies that have been incorporated organization-wide to include:
  - Diverse population and disability training initiatives, based upon the National Advisory Board's focus on cultural competency;

- o Americans with Disabilities Act (ADA) training, based upon the National Advisory Board's focus on individuals with disabilities;
- o Clinical training on elder abuse, based upon the National Advisory Board's focus on elderly care, abuse and neglect.
  - In 2015, UHCCP expanded the Member Advisory Committee to include members who reflect their diverse community agencies and membership across Nebraska. These members represent various community resource agencies, cultures, family dynamics, urban and rural settings and a foundation for broad community connectedness to improve coordinated care for members. There are two committee structures: general member committee members and a Native American committee that meet four times a year. The committee has provided input that was used to enhance member materials, digital communications and service gaps.

UHCCP is fully committed to supporting the objectives of the Nebraska Heritage Health Program to reduce racial and ethnic health disparities. The MCO assesses the cultural, ethnic, racial, and linguistic composition of the network against the needs and preferences of enrollees and adjusts the availability of practitioners within the network, as necessary. The MCO performs analysis on accessibility to tribal providers to ensure Native American members have direct access to tribal providers. These assessments help drive the disparities action plan the MCO has developed to address disparities, which includes outreach and committee activities in addition to clinical interventions to promote gap closure in a culturally sensitive manner.

WellCare Health Plan of Nebraska

Throughout the course of 2017, WellCare undertook several community initiatives aimed at addressing healthcare disparities among their membership:

Health Disparities education series
WellCare of Nebraska hosted monthly health disparities focused lunch n learn sessions at their Omaha offices. Subject matter experts across the state shared their expertise with WellCare staff and community partners. The year culminated with a 3 hour session of "The Last straw" poverty simulation played at WellCare's Omaha office.
The series will continue throughout 2018 and will include viewings and discussions of Unnatural Causes (a documentary exploring racial and socioeconomic inequities in health), and a multi series session exploring Cultural Intelligence. Staff and community partners are invited to join in this important discussion and will be able to participate remotely at a local Welcome Room and in some cases telephonically.

Community garden
WellCare of Nebraska leased 10 garden beds from City Sprouts South. Staff planted and maintained the beds throughout the year. The area surrounding the community garden is recognized as a certified food desert making access to affordable, healthy foods very limited. Local residents in the low income neighborhood were allowed to harvest and keep any of the fresh foods they wanted.

Cooking Matter partnership
Cooking Matters' program ensures that low income families get the tools they need to stretch their food budgets and cook healthy meals so that children get nutritious food at home. WellCare of Nebraska Community Relations staff have all been trained to facilitate interactive grocery store tours. Tours provide hands- on education as the participants learn how to read food labels and make smart choices about the foods they choose. Community Relations Specialists will also partner with Cooking Matters nutritionists to lead 6 week cooking courses in Welcome Rooms across the state.

American Diabetes Association partnership
WellCare of Nebraska's sponsorship of the Diabetes Busters program will allow Community Relations specialists to receive certification to facilitate the curriculum to school aged children. The Diabetes Busters program will be delivered across the state and will teach children the science behind diabetes, the impact of food on diabetes and the importance of physical activity and how it relates to the food they eat and diabetes. Diabetes Busters sessions will be offered in Welcome Rooms across the state and as "patch" earning activities for local Scouts troops.

Care Management
The Nebraska Care Management Leadership is working with our shared Services partners to adjust our algorithm to identify at risk members in need of care management to be inclusive of a social determinates score.
Every member engaged in care management is screened for health disparities in their assessments. The outcome of this assessment allows the care manager to work collaboratively with the member to address these disparities inclusive to their care for their medical and behavioral health.
WellCare has a designated care manager who acts as our housing coordinator
The State awarded to participate in the CMS Medicaid Housing Innovation Acceleration Program. WellCare has an active participant from CM leadership engaged in this work.
Three WellCare employees participate as committee members for the NE Special Olympics Medical Advisory Committee.

Future Initiative: *Mini Farmers markets*
From June – August 2018 WellCare of Nebraska will host 5 mini farmers markets in different locations across the state. The markets will be held in Buffalo, Thurston, Scottsbluff and Madison counties. These counties have been identified as counties in the top 10% experiencing food insecurity across the state. Each mobile pantry will feed up to 200 families and will assist families with feeding children throughout the day during the summer months.

Appendix A: Compliance Monitoring

Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358, delineates that a review of an MCE's compliance with standards established by the State to comply with the requirements of § 438 Subpart E is a mandatory EQR activity. Further, this review must be conducted within the previous three-year period, by the State, its agent, or the EQRO.

NE DHHS annually evaluates the MCE's performance against contract requirements and state and federal regulatory standards through its EQRO contractor, as well as by an examination of each MCE's accreditation review findings. As permitted by federal regulations, in an effort to prevent duplicative review, NE DHHS utilizes the accreditation findings, where determined equivalent to regulatory requirements.

In order to determine which regulations must be reviewed annually, IPRO performs an assessment of the MCE's performance on each of the federal managed care regulations over the prior three-year period. Results of both the EQRO reviews and accreditation survey are examined. The following guidelines are used to determine which areas are due for assessment:

- Regulations for which accrediting organization standards have been cross-walked and do not fully meet equivalency with federal requirements.
- Regulations that are due for evaluation, based on the three-year cycle.
- Regulations for which the MCE received less than full compliance on the prior review by either the EQRO or accrediting organization. Please note that the prior review in this case consisted of the MCOs' readiness review.
- State and contract-specific requirements beyond the federal managed care regulatory requirements.
- Areas of interest to the State, or noted to be at risk by either the EQRO and/or State.
- Note that Quality Management: Measurement and Improvement – Quality Assessment and Performance improvement (QAPI) (42 CFR 438.240) is assessed annually, as is required by federal regulations.

The annual compliance review for January – August 2017, conducted in September 2017 addressed contract requirements and regulations within the following categories:

- Grievances and Appeals;
- Member Services and Education;
- Care Management;
- Quality Management
- Utilization Management;
- Provider Network; and
- Subcontracting

Data collected from each MCO either submitted pre-onsite, during the onsite visit, or in follow-up, was considered in determining the extent to which the MCO was in compliance with the standards. Further, descriptive information regarding the specific types of data and documentation reviewed is provided in the section "Description of Data Obtained" below and in this report under section, Compliance Monitoring.

Technical Methods of Data Collection

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCEs. For each set of standards reviewed, IPRO prepared standard-specific review tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- statement of federal regulation and related federal regulations;
- statement of state regulations;

- statement of state and MCO contract requirement(s);
- suggested evidence;
- reviewer determination;
- prior results (based on Readiness Review);
- descriptive reviewer findings and comments related to findings; and
- MCO response and action plan

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.

Reviewer findings on the tools formed the basis for assigning preliminary and final determinations. The standard determinations used are listed in **Table A.1**.

Table A.1: Standard Compliance Determinations

Standard Determinations	
Full Compliance	MCO has met or exceeded the standard
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action
Non-compliance	MCO has not met the standard

The list of elements due for review and the related review tools were shared with NE DHHS and each MCO.

Pre-onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports. Additional documents were requested to be available for the onsite visit, such as reports and case files.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing of grievances received by the MCO for a selected time period; or, for care coordination, a listing of members enrolled in care management during a selected time period. From these listings, IPRO selected a random sample of files for review onsite.

Additionally, IPRO began its "desk review" or offsite review when the pre-onsite documentation was received from the MCOs. Prior to the review, a notice was sent to the MCOs including a confirmation of the onsite dates, an introduction to the review team members, the onsite review agenda, and an overall timeline for the compliance review activities.

Onsite Activities – The onsite review commenced with an opening conference, where staff was introduced, and an overview of the purpose and process for the review including the onsite agenda was provided. Following the opening conference, IPRO conducted review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow up items needed, and the next steps in the review process.

Description of Data Obtained

As noted in the Pre-onsite Activities section, in advance of the review IPRO requested documents relevant to each standard under review, to support each MCO's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI Program Description, Work Plan, and Annual Evaluation; Member and Provider Handbooks; access reports; committee descriptions and

minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow up. Additionally, as reported above under Onsite Activities, staff interviews and demonstrations were conducted during the onsite visit. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the 2017 review is contained in the Compliance Monitoring section of this report.

Data Aggregation and Analysis

Post-onsite Activities – Following the onsite review, the MCOs were provided with a limited time period to submit additional documentation while IPRO prepared the preliminary review findings. As noted earlier, each standard reviewed was assigned a level of compliance ranging from Full Compliance to Non-Compliance. The review determination was based on IPRO's assessment and analyses of the evidence presented by the MCO. For standards where an MCO was less than fully compliant, IPRO provided in the review tool a narrative description of the evidence reviewed, and reason for non-compliance. Each MCO was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. IPRO reviewed any responses submitted by the MCO and made final review determinations.

Appendix B: Validation of Performance Improvement Projects

Objectives

Medicaid MCEs implement performance improvement projects (PIPs) to assess and improve processes of care, and as a result improve outcomes of care. The goal of PIPs is to achieve significant and sustainable improvement in clinical and nonclinical areas. A mandatory activity of the EQRO is to review PIPs for methodological soundness of design, conduct and report to ensure real improvement in care and confidence in the reported improvements.

PIPs were reviewed according to the CMS protocol described in the document "Validating Performance Improvement Projects". The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following ten elements:

- Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment
- Review of the study question(s) for clarity of statement
- Review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the PIP
- Review of the identified study population to ensure it is representative of the MCO enrollment and generalizable to the MCO's total population
- Review of sampling methods (if sampling used) for validity and proper technique
- Review of the data collection procedures to ensure complete and accurate data was collected
- Assessment of the improvement strategies for appropriateness
- Review of the data analysis and interpretation of study results
- Assessment of the likelihood that reported improvement is "real" improvement
- Assessment of whether the MCO achieved sustained improvement

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable. Note that, since the PIPs were first proposed in 2017, a review of findings was not applicable for any of the projects represented within this report.

Technical Methods of Data Collection

The methodology for validation of the PIPs was based on the CMS protocol for "Validating Performance Improvement Projects". Each PIP was reviewed using this methodology upon proposal submission. Upon first re-measurement and each re-measurement thereafter, each of the ten protocol elements will be considered.

Description of Data Obtained

Each PIP was validated using the MCO's PIP project reports, and in collaboration with DHHS's data and analytics team (to validate statewide averages, and compare state-collected MCO rates against what the MCOs reported in their proposals). Data obtained at the proposal stage included baseline, benchmark, and goal rates.

Data Aggregation and Analysis

Each applicable protocol element necessary for a valid PIP is documented within this report. Being that only PIP proposals were available for evaluation in MY 2017, analysis included review of the study topic, questions, indicators, target population, and data collection procedures. Sampling was not applicable within any of the PIPs.

Upon final reporting, a determination will be made as to the overall credibility of the results of each PIP, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility of the PIP results is at risk.
- The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution. Processes that put the conclusions at risk will be enumerated.

- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk will be enumerated.