



**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 2017–2018  
April 2019**



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realized.

Corporate Headquarters  
1979 Marcus Avenue  
Lake Success, NY 11042-1072  
(516) 326-7767  
ipro.org

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## 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.

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 MCEs.

### Scope of EQR Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.358, these activities were:

**Compliance Review** – This review determines MCE 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)** – PIPs were reviewed to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

**Validation of Performance Measures (PMs)** – IPRO reviewed the HEDIS audit results provided by the MCO’s National Committee for Quality Assurance (NCQA) HEDIS compliance auditor and the reported MCO performance measure rates.

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 **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** section of this report.

### 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 MCEs’ strengths and IPRO’s recommendations with respect to quality, timeliness, and access. Specific findings, strengths, and recommendations are described in detail in **Findings, Strengths and Recommendations with Conclusions Related to health Care Quality, Timeliness and Access** in this report.

## Nebraska Total Care Quality

The quality domain encompasses PIP activities, HEDIS performance, and findings from six (6) of the eight (8) compliance domains: Member Services and Education, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management.

### PIPs

In 2017, NTC submitted proposals for three PIP topics; Improving Follow-up After Emergency Department (ED) Visit for Mental Health Illness (MHI) or Substance Use Disorder (SUD), Initiation of 17P in Pregnant Women, and Tdap Vaccination for Pregnant Women. Throughout 2018, the MCO submitted quarterly updates to demonstrate their progress in carrying out interventions and meeting objectives. NTC has demonstrated improvement in the percentage of members (13–17 and 18 years of age or older) who had a 7-day follow-up after an ED visit for SUD, and the percentage of members (13–17 and 18 years of age or older) who had a 30-day follow-up after an ED visit for SUD. In contrast, the rates for members with 7- or 30-day follow-up after ED visit for MHI have declined. For their 17P PIP, data analysis reveals a significant improvement in the percentage of pregnant members with a history of preterm birth who received 17P. Similarly, the prevalence of Tdap vaccination has improved significantly, both anytime during pregnancy and during the optimal gestational age period.

### HEDIS Performance

For HEDIS 2018, NTC performed **better than** the national Medicaid HMO averages for:

- Use of Imaging for Low Back Pain
- Antidepressant Medication Management – Effective Acute Phase
- Antidepressant Medication Management – Effective Continuation Phase

The MCO reported rates **below** the national Medicaid HMO averages for:

- Child/Adolescent BMI Assessment
- Child/Adolescent Counseling for Nutrition
- Child/Adolescent Counseling for Physical Activity
- Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Adolescent Immunizations – Combination
- Childhood Immunizations – Combinations 2, 3, and 10
- Comprehensive Diabetes Care Blood Pressure < 140/90
- Controlling High Blood Pressure

Of note, the rates for Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Adolescent Immunizations – Combination 1, Childhood Immunizations – Combinations 2, 3, and 10, and Controlling High Blood Pressure were **at or below** the national Medicaid 10th percentile.

### Compliance Review

NTC received a “substantial compliance” designation for Member Services and Education, Provider Services, Grievances and Appeals, Quality Management, and Utilization Management. NTC received a “full compliance” designation for Subcontracting:

- Of the 61 standards/substandards reviewed for Member Services and Education, 54 were fully compliant, four (4) were substantially compliant, and three (3) were minimally compliant. The following details findings from the review of these substantially and minimally compliant standards:  
Substantially Compliant Standards
  - NTC provided a map of Nebraska’s I/T/U: Indian health services, tribal health providers, and urban Indian health providers (I/T/U) provider network across all counties; however, the map could not be effectively interpreted due to the omission of a key/legend.

- Information about the NTC member website and what is on the website is found within the member handbook; however, there is no verbiage which explains how the member can obtain written materials if they do not have access to the website.
- The MCO provided examples of written materials such as: member handbook, statement of nondiscrimination, member brochure, and annual member mailing. These are all clearly legible on the computer screen; however, it is difficult to determine the font size, as these documents are in PDF format and screenshots of the website. This requirement was not included in the policy/procedure provided.
- There was no verbiage in the member handbook stating the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state.

#### Minimally Compliant Standards

- The MCO's annual member mailing does not have verbiage that describes to the member that they have the option to receive the member handbook and provider directory in paper or electronic format. This information was also not found in the member handbook.
  - The annual member mailing does not have verbiage that describes to the member that they have the right to disenrollment from the MCO.
  - The annual member mailing does not have verbiage that describes to the member that they have the option to receive the member handbook and provider directory at no cost.
- Of the four (4) standards/substandards reviewed for Provider Services, one (1) was fully compliant and three (3) were substantially compliant. The following details findings from the review of these substantially compliant standards:
    - As it is currently written, the provider complaint process lacks clarity and timeframes are inconsistently described.
    - The provider grievance acknowledgment letter addresses member grievances, not provider complaints. Likewise, the template grievance inquiry letter is related to member grievances, not provider complaints. NTC explained that these templates are used for both member and provider grievances. The templates apply to member grievances filed by members or providers filing on behalf of a member, but not for provider complaints.
    - The provider manual does not include a discrete section related to provider grievances and complaints.
  - Of the 39 standards/substandards reviewed for Grievances and Appeals, 35 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. All of these standards except for one (1) apply to the quality domain (the one that does not is presented below, under **Timeliness**). The following details findings from the review of these substantially and minimally compliant standards related to quality:
    - Substantially Compliant Standard
      - There was no language in the grievance policy/procedure, member handbook, or provider manual which implies MCO must "ensure that there is only one level of appeal for members" in the documentation provided.
      - One (1) expedited appeal file was reviewed and did not contain evidence that the MCO provided the member with verbal notice of resolution.

#### Minimally Compliant Standard

- There was no language found in the documentation provided that states "A member can file a grievance with the MCO or state at any time."
- Of the 58 standards/substandards reviewed for Quality Management, 56 were fully compliant, one (1) was substantially compliant, and one (1) was not applicable. The following details findings from the review of this substantially compliant standard:
    - Information for each member of the member advisory committee was not included in the MCO's report to Medicaid and Long-Term Care (MLTC).
  - Of the 65 standards/substandards reviewed for Utilization Management, 63 were fully compliant and two (2) were substantially compliant. One (1) of these standards applies to the quality domain (the other to timeliness, and is

documented below, accordingly). The following details findings from the review of this substantially compliant standard related to quality:

- The wording from the state contract related to monitoring providers' utilization of services by race, ethnicity, gender, and age was not included in the policies provided.

In the domain of quality, IPRO recommends that NTC:

- Continue targeting PIP interventions towards susceptible subpopulations, while focusing on the rates for follow-up after ED visit for MHI, identifying barriers and corresponding interventions as appropriate.
- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid HMO average.
- Provide a map key or explanation of the I/T/U provider coverage map on the next compliance review so that it can be interpreted accurately.
- Provide members with information on how to obtain written materials if the member does not have access to their website.
- Specify the minimum font size of member materials in a policy/procedure, and provide materials that are in a Word document format for the next compliance review.
- Add verbiage to the member handbook which states the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state.
- Provide members with written notification at least once a year that states that they can receive the member handbook and provider directory in paper or electronic format.
- Provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.
- Inform members of the right to obtain the member handbook and provider directory at no cost.
- Develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request, and for resolution. The criteria used to define a provider complaint versus a provider grievance should be documented, including how each is tracked and reported. The provider complaint policy/procedure should also describe how complaints from out-of-network providers are handled.
- Develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request, and for resolution.
- The NTC provider manual and website should include separate descriptions and instructions for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. NTC should ensure consistency across policies/procedures, the provider manual, and the website.
- Include the verbiage that there is only one level of appeal for members in the applicable policies, provider manual, and member handbook.
- Provide verbal notice of resolution of expedited appeals. Further, this verbal notice should be documented in the case notes for each expedited appeal.
- The NTC provider manual and website should include separate descriptions and instructions for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. NTC should ensure consistency across policies/procedures, the provider manual, and the website.
- Add language to their member handbook, website, and all applicable policies that indicates a member may file a grievance at any time with the MCO or state.
- Include the name, address, and organization represented for each member on the Member Advisory Committee (MAC).
- Add language from the state contract related to monitoring providers' utilization of services by race, ethnicity, gender, and age to appropriate NTC policies.

### **Timeliness**

The timeliness domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Utilization Management, and Grievances and Appeals.

## HEDIS Performance

For HEDIS 2018, NTC performed **better than** the national Medicaid HMO averages for:

- Monitoring for Persistent Medications
- Comprehensive Diabetes Care – HbA1c Measurement

NTC reported rates **below** the national Medicaid HMO averages for:

- Pharmacotherapy Management of COPD – Systemic Corticosteroid
- Pharmacotherapy Management of COPD – Bronchodilator
- Appropriate Treatment for URI
- Appropriate Pharyngitis Testing
- Cervical Cancer Screening
- Chlamydia Screening
- Comprehensive Diabetes Care – Retinal Exam
- Comprehensive Diabetes Care – Nephropathy Monitoring
- Timeliness of Prenatal Care
- Postpartum Exam
- Well-Child Visits 3–6 Years
- Adolescent Well-Care Visits

Of note, the rates for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Comprehensive Diabetes Care – Nephropathy Monitoring, Postpartum Exam, and Well-Child Visits 3–6 Years were **at or below** the national Medicaid 10th percentile.

## Compliance Review

NTC received a “substantial compliance” designation for Grievances and Appeals and Utilization Management:

- Of the 39 standards/substandards reviewed for Grievances and Appeals, 35 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. Only one (1) of these standards applied to timeliness. The following details findings from the review of the one (1) substantially compliant standard within the timeliness domain:
  - Sixteen (16) of 20 grievance files contained evidence of a timely acknowledgement letter; the remaining four (4) grievance files contained acknowledgement letters that were dated past 10 calendar days after the request was received.
- Of the 65 standards/substandards reviewed for Utilization Management, 63 were fully compliant and two (2) were substantially compliant. One (1) of these standards applies to the timeliness domain. The following details findings from the review of this substantially compliant standard related to timeliness:
  - One (1) of 10 denial files reviewed exceeded the 14-day timeframe for notice of decision following receipt of the request for service authorization.

In the domain of timeliness, IPRO recommends that NTC:

- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid HMO average.
- Ensure timely acknowledgment letters are provided for all members who file a grievance.
- Ensure timely notification of decision following request for service authorization.

## **Access**

The access domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Care Management and Provider Network.

## HEDIS Performance

For HEDIS 2018, NTC performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)
- Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)
- Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years)
- Ambulatory Care – ED Visits/1,000 MM

Of note, the rate(s) for Children and Adolescents' Access to Primary Care Practitioners (12–24 Months) and Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years) were **at or above** the national Medicaid 90th percentile.

NTC did not report any rates below the national Medicaid HMO average for any measure within the access domain.

### Compliance Review

NTC received a “full compliance” designation for Care Management and “substantial compliance” for Provider Network:

- Of the 65 standards/substandards reviewed for Provider Network, 61 were fully compliant, three (3) 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

- The MCO has a policy regarding nondiscrimination of Indians; however, this policy does not include all state contract requirements. During the onsite review, the MCO provided additional evidence of addressing non-discrimination; however, evidence of all state contract requirements could not be found in the provider manual or member handbook.
- The MCO's network adequacy policy describes its behavioral health network; however, the policy does not include the behavioral health conditions specified in the standard.
- The MCO's policy includes the 45-minute wait time standard. Page 24 of the contract (the NTC preferred provider arrangement [PPA]) states 45 minutes; however, the provider manual (page 18) states one (1) hour. Similarly, the member handbook states one (1) hour as well.

#### Minimally Compliant Standard

- Language not limiting providers from contracting with another MCO could not be located in NTC's policy or in the provider contract.

In the domain of access, IPRO recommends that NTC:

- Update their policy to include each of the contract requirements. Additionally, the MCO should update the provider manual and member handbook to include the contract requirements.
- Update the policy to specify the behavioral health conditions described in the state contract.
- Update the provider manual and member handbook to reflect the 45-minute wait time requirement.
- Update policy NE.CONT.01 and the provider contract to include language to meet this requirement.

## **UnitedHealthcare Community Plan of Nebraska** **Quality**

The quality domain encompasses PIP activities, HEDIS performance, and findings from six (6) of the eight (8) compliance domains: Member Services, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management.

### PIPs

In calendar year (CY) 2018, the MCO continued work on the three (3) PIP topics: Improving Follow-up After Emergency Department (ED) Visit for Mental Health Illness or Substance Use Disorder (SUD), Initiation of 17P in Pregnant Women, and Tdap Vaccination for Pregnant Women. 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). Baseline data were collected for CY 2017 and demonstrate an opportunity for improvement across both measures, as rates for both measures declined from baseline in 2018. For the 17P initiation PIP, preliminary data analysis of the performance indicator for CY 2018 demonstrated improvement from baseline (25.6%) in the percentage of at-risk pregnant members

who received 17P to 27.3%. For the Tdap PIP, analysis of preliminary data for CY 2018 demonstrated a slight decrease from baseline in the percentage of members who received the Tdap vaccine during pregnancy. Similarly, there was a decrease from baseline for the percentage of members who received the Tdap vaccine during the optimal 27–36-week gestational age period.

### HEDIS Performance

For HEDIS 2018, UHCCP performed **better than** the national Medicaid HMO averages for:

- Adult BMI Assessment
- Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Adolescent Immunizations – Combination 1
- Childhood Immunizations – Combination 2
- Childhood Immunizations – Combination 3
- Childhood Immunizations – Combination 10
- Comprehensive Diabetes Care Blood Pressure < 140/90
- Controlling High Blood Pressure
- Use of Imaging for Low Back Pain
- Antidepressant Medication Management – Effective Acute Phase
- Antidepressant Medication Management – Effective Continuation Phase

UHCCP reported rates **below** the national Medicaid HMO averages for the following measures:

- Child/Adolescent BMI Assessment
- Child/Adolescent Counseling for Nutrition
- Child/Adolescent Counseling for Physical Activity
- Medication Management for People with Asthma – 75%

Of note, the rates for Childhood Immunizations – Combination 2, Childhood Immunizations – Combination 3, Childhood Immunizations – Combination 10, Antidepressant Medication Management – Effective Acute Phase, and Antidepressant Medication Management – Effective Continuation Phase were **at** the national Medicaid 90th/95th percentile. The rate for Child/Adolescent BMI Assessment was **at** the national Medicaid 10th percentile.

### Compliance Review

UHCCP received a “full compliance” designation for Subcontracting, Provider Services, Utilization Management, and Quality Management, and a “substantial compliance” designation for Grievances and Appeals and Member Services and Education:

- Of the 39 standards/substandards reviewed for Grievances and Appeals, 38 standards/substandards were fully compliant and one (1) was substantially compliant. The following details findings from the review of this substantially compliant standard:
  - A member may file a grievance with the MCO or the state at any time. However, this language was not outlined explicitly in the grievances section of the member handbook (on page 111).
- Of the 61 standards/substandards reviewed for Member Services and Education, 60 were fully compliant and one (1) was substantially compliant. The following details the findings from the review of this substantially compliant standard:
  - The MCO must make a good-faith effort to provide affected members with written notice of a provider’s termination from the MCO’s network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider. Letters sent to members were not timely.

In the domain of quality, IPRO recommends that UHCCP:

- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid health maintenance organization (HMO) average.
- The MCO should consider incorporating language related to filing a grievance at any time on page 111. Further, the MCO should ensure that the new template outlining the member's right to file a complaint regarding civil rights discrimination at any time is consistently being utilized.
- UHCCP should examine the timeliness of the letters that are distributed to members, and ensure that members are notified within 15 days of when the MCO receives the termination notice from the provider.

## Timeliness

The timeliness domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Utilization Management, and Grievances and Appeals.

### HEDIS Performance

For HEDIS 2018, UHCCP performed **better than** the national Medicaid HMO averages for:

- COPD Spirometry Testing
- Pharmacotherapy Management of COPD – Systemic Corticosteroid
- Pharmacotherapy Management of COPD – Bronchodilator
- Monitoring for Persistent Medications
- Appropriate Treatment for URI
- Breast Cancer Screening
- Comprehensive Diabetes Care – Retinal Exam
- Comprehensive Diabetes Care – HbA1c Measurement
- Comprehensive Diabetes Care – Nephropathy Monitoring
- Follow-up for ADHD Medication – Initiation Phase
- Postpartum Exam
- Well-Child Visits (0–15 Months, 6+ Visits)
- Adolescent Well-Care Visits

UHCCP reported rates **below** the national Medicaid HMO averages for:

- Appropriate Pharyngitis Testing
- Cervical Cancer Screening
- Chlamydia Screening
- Follow-up for ADHD Medication – Continuation and Maintenance Phase
- Timeliness of Prenatal Care
- Well-Child Visits (3–6 Years)

Of note, the rates for Pharmacotherapy Management of COPD – Bronchodilator and Well-Child Visits (3–6 Years) were at the national Medicaid 90th/95th percentile. The rates for Appropriate Pharyngitis Testing and Chlamydia Screening were **at or below** the national Medicaid 10th percentile.

### Compliance Review

All Utilization Management (UM) and Grievances and Appeals files reviewed demonstrated that elements were completed on time.

In the domain of timeliness, IPRO recommends that UHCCP:

- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid health maintenance organization (HMO) average.

## Access

The access domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Care Management and Provider Network.

## HEDIS Performance

For HEDIS 2018, UHCCP performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)
- Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)
- Children and Adolescents' Access to Primary Care Practitioners (7–11 years)
- Children and Adolescents' Access to Primary Care Practitioners (12–19 years)
- Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years)
- Ambulatory Care – ED Visits/1,000 MM

Of note, the rates for Children and Adolescents' Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, and 12–19 Years) and Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years) are **at** the national Medicaid 90th/95th percentile. The rate for Ambulatory Care – ED Visits/1,000 MM was **at** the national Medicaid 10th percentile.

## Compliance Review

UHCCP received a “full compliance” designation for Care Management and Provider Network.

There are no recommendations in the domain of access at this time.

## **WellCare Health Plan of Nebraska** **Quality**

The quality domain encompasses PIP activities, HEDIS performance, and findings from six (6) of the eight (8) compliance domains: Member Services, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management.

### PIPs

In 2017, WellCare submitted proposals for three PIP topics: Improving Follow-up After Emergency Department (ED) Visit for Mental Health Illness (MHI) or Substance Use Disorder (SUD), Initiation of 17P in Pregnant Women, and Tdap Vaccination for Pregnant Women. Throughout 2018, the MCO submitted quarterly updates to demonstrate their progress in carrying out interventions and meeting objectives. WellCare has demonstrated improvement in follow-up after an ED visit for SUD for members 18 years of age or older; however, for those 13–17 years of age, these rates have declined (note the denominator for this age cohort is quite small, and thus this decline should be interpreted with caution). Similarly, rates for follow-up after an ED visit for MHI (across all age cohorts) has declined. For WellCare's 17P PIP, data analysis demonstrates a decline in the percentage of pregnant members with a history of preterm birth who received 17P. The MCO suspects this may have to do with a shortage of Makena and, as such, has expressed the intention of outreaching specialty pharmacies in 2019 to assess their access to this prophylactic therapy. Lastly, for WellCare's Tdap PIP, data analysis demonstrates a slight increase in each indicator (0.8 percentage point increase in the percentage of pregnant members who received Tdap at any point during pregnancy, and a 1.1 percentage point increase in the percentage of pregnant members who received Tdap during the optimal 27- to 36-week gestational age period). Although marginal, these improvements are notable, given the increase in denominator from 2017 to 2018 (2,481 pregnant members in 2017 to 3,257 in 2018).

## HEDIS Performance

For HEDIS 2018, WellCare performed **better than** the national Medicaid HMO averages for:

- Lead Screening in Children
- Childhood Immunizations – Combination 10
- Comprehensive Diabetes Care Blood Pressure < 140/90
- Controlling High Blood Pressure
- Use of Imaging for Low Back Pain
- Antidepressant Medication Management – Effective Acute Phase
- Antidepressant Medication Management – Effective Continuation Phase

WellCare reported rates **below** the national Medicaid HMO averages for:

- Child/Adolescent BMI Assessment
- Child/Adolescent Counseling for Nutrition
- Child/Adolescent Counseling for Physical Activity
- Human Papillomavirus Vaccine for Female Adolescents
- Adolescent Immunizations – Combination 1
- Childhood Immunizations – Combination 2
- Childhood Immunizations – Combination 3

Of note, the rates for Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Childhood Immunizations – Combination 2, and Childhood Immunizations – Combination 3 were **at or below** the national Medicaid 10th percentile.

### Compliance Review

WellCare received a “substantial compliance” designation for Member Services and Education, Provider Services, Quality Management, Utilization Management, and Grievances and Appeals (note the standards determined to be substantial for Grievances and Appeals relate to timeliness, not quality, and thus are not reflected within this section). The MCO demonstrated full compliance for Subcontracting:

- Of the 61 standards/substandards reviewed for Member Services and Education, 59 were fully compliant and two (2) were substantially compliant. The following details findings from the review of the substantially compliant standards:
  - There was no language within the policies and procedures, which states the following: “The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately.”
  - There was a discrepancy for the number of days the MCO must distribute member materials: the policy states within 30 days; however, the state contract states within 10 days.
- Of the four (4) standards/substandards reviewed for Provider Services, all were substantially compliant. The following details the findings from the review of these standards:
  - WellCare’s policies/procedures do not clearly define informal complaints (disputes) or formal provider complaints. Further, policies/procedures do not include a description of how each is tracked and reported.
  - A process for reporting provider complaints is not documented.
  - The policies/procedures that describe the provider complaint system do not include several of the contractual requirements.
  - The resolution timeframe stated within the provider handbook is not consistent with the timeframe outlined in the MCO policy.
- For Quality Management, a total of 58 standards/substandards were reviewed. Fifty-five (55) standards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. The following details findings from the review of substantially compliant standards:
  - There was an opportunity for representation on the Quality Assurance and Performance Improvement Committee (QAPIC) of providers’ knowledgeable about disability, mental health, and substance use disorder.
  - WellCare submitted the Member Advisory Committee (MAC) PowerPoint training; however, it was dated for 2016.
- Of the 65 standards/substandards reviewed for Utilization Management (UM), 63 were fully compliant and two (2) were substantially compliant. One (1) of these standards is related to quality. The following details findings from the review of this substantially compliant standard:
  - The UM program description did not detail processes and procedures to address disparities in healthcare.

In the domain of quality, IPRO recommends that WellCare:

- Target members with an ED visit for MHI to ensure they receive appropriate follow-up. Continue exploring barriers that may impede follow-up and implement interventions, as appropriate.
- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid health maintenance organization (HMO) average. These measures all pertain to children/adolescents.
- Include language within policies/procedures relating to oral interpretation and written translation services, which includes the written standard of providing translation services for all written marketing member materials in any language spoken by 4% or more of the MCO's membership.
- Update the WellCare website policy to reflect the 10-calendar-day standard within which the MCO must distribute member materials to each new member.
- Clearly define informal complaints (disputes) and formal provider complaints and include a description of how each is tracked and reported within applicable policies/procedures.
- Document and implement a process for reporting provider complaints.
- Implement an updated provider complaint system policy addressing all contract requirements, and ensure provider complaints are resolved within MCO-defined timeframe. Ensure that the MCO website and provider handbook are consistent with the updated policy.
- Update the MAC PowerPoint training presentation to include the appropriate year, and provide further evidence of these trainings (such as attendance sheets) going forward.
- Incorporate the required language related to disparities in healthcare in the Utilization Management (UM) Program Description, and create policies and procedures to address disparities in healthcare.

## Timeliness

The timeliness domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Utilization Management, and Grievances and Appeals.

### HEDIS Performance

For HEDIS 2018, WellCare performed **better than** the national Medicaid HMO averages for:

- Monitoring for Persistent Medication
- Comprehensive Diabetes Care – HbA1c Measurement
- Comprehensive Diabetes Care – Nephropathy Monitoring
- Adolescent Well-Care Visits

The MCO reported rates **below** the national Medicaid HMO averages for:

- Pharmacotherapy Management of COPD – Systemic Corticosteroid
- Pharmacotherapy Management of COPD – Bronchodilator
- Appropriate Treatment for URI
- Appropriate Pharyngitis Testing
- Cervical Cancer Screening
- Chlamydia Screening
- Comprehensive Diabetes Care – Retinal Exam
- Timeliness of Prenatal Care
- Postpartum Exam
- Well-Child Visits (3–6 Years)

Of note, the rates for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, and Postpartum Exam were **at or below** the national Medicaid 10th percentile.

### Compliance Review

WellCare received a “substantial compliance” designation for Utilization Management and Grievances and Appeals:

- Of the 39 standards/substandards that were reviewed for Grievances and Appeals, 38 were fully compliant and one (1) was substantially compliant. The following details findings from the review of the substantially compliant standard:
  - In one (1) of 20 grievance files, the acknowledgement letter was dated more than 10 calendar days after receipt of the grievance.
- Of the 65 standards/substandards reviewed for UM, 63 were fully compliant and two (2) were substantially compliant. One (1) of these standards is related to timeliness. The following details findings from the review of this substantially compliant standard:
  - One (1) of 10 files reviewed demonstrated that the denial letter was not sent to the member within the allowable 14-day time period from when the service authorization request was received.

In the domain of timeliness, IPRO recommends that WellCare:

- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid HMO average.
- Implement a process to assess ability to comply with the timeliness standard for service authorization denials and acknowledgment letters for grievances and appeals.

## Access

The access domain includes HEDIS performance and findings from two (2) of the eight (8) compliance domains: Care Management and Provider Network.

### HEDIS Performance

For HEDIS 2018, WellCare performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)
- Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)
- Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years)
- Ambulatory Care – ED Visits/1,000 MM (note for this measure a lower rate is desirable)

### Compliance Review

WellCare received a “substantial compliance” designation for Care Management and Provider Network, and a “full compliance” designation for Subcontracting:

- For Care Management, 59 standards/substandards were reviewed. Fifty (50) standards/substandards were fully compliant, eight (8) were substantially compliant, and one (1) was non-compliant. The following details findings from the review of these substantially and non-compliant standards:

#### Substantially Compliant Standards

- Sixteen (16) of 20 files reviewed included self-management strategies. One (1) file did not meet the requirement and one (1) file was not applicable.
- Twelve (12) of 20 files reviewed included a risk stratification level. For the remaining eight (8) files, WellCare produced a separate listing of this information.
- The plan of care in one (1) file was not implemented until two (2) months after the health risk assessment was completed.
- One (1) file lacked evidence of assistance with appointment scheduling and identifying participating providers.
- One (1) file lacked evidence of assistance with care management (CM) and accessing primary care, behavioral health, and preventive and specialty care.
- Two (2) files lacked evidence of continuity of care (including collaboration and communication with other providers involved in a member's transition to another level of care).
- Two (2) files did not demonstrate facilitation of relapse prevention.
- In terms of coordination with the Division of Children and Family Services, WellCare provided a policy for behavioral health collaboration; however, a policy for non-behavioral health collaboration was not provided.

### Non-Compliant Standard

- The procedure WellCare submitted to demonstrate criteria for maintaining care plans and referral services when a member changes PCPs addresses transition to another MCO, but does not address transition to another PCP.

In the domain of access, IPRO recommends that WellCare:

- Ensure that all members engage in self-management strategies for identified diseases/conditions and that these strategies are documented in the case file.
- Document the assigned risk stratification level in each care management file.
- A plan of care should be implemented timely upon member enrollment in care management and completion of the health risk assessment.
- As needed, care management files should reflect assistance with appointment scheduling and identification of participating providers.
- As needed, care management files should reflect assistance with accessing primary care, behavioral health, and preventive and specialty care.
- As needed, care management files should reflect continuity of care, including collaboration and communication with other providers involved in a member's transition to another level of care. Appropriate personnel including the PCP should be kept informed of the member's treatment needs, changes, progress, or problems.
- Care management files should include relapse prevention plans for members with depression and other high-risk behavioral health conditions. WellCare should partner with behavioral health providers to develop a universal relapse condition plan for higher volume patient needs, such as depression.
- WellCare should establish a policy for non-behavioral health care coordination with the Division of Children and Family Services.
- WellCare should establish a policy/procedure that addresses maintenance of care plans and referral services when a member changes PCPs.

## MCNA

### Quality

The quality domain encompasses PIP activities and findings from six (6) of the seven (7) compliance domains: Member Services, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management.

#### PIPs

In calendar year (CY) 2018, MCNA proposed a PIP to increase the percentage of members receiving annual dental visits. The PIP employs the modified HEDIS Annual Dental Visit (ADV) measure, stratified into three age groups: 2–20 years, 1–20 years, and 21+ years. The baseline period for the PIP was 1/1/18–12/31/18. Analysis of MCNA's baseline data showed the ADV rate for ages 2–20 was 68.2%, the rate for ages 1–20 was 64.9%, and the rate for ages 21+ was 42.6%. The final goal for ages 2–20, 1–20, and 21+ were 69.7%, 67.9%, and 44.1%, respectively.

MCNA is also conducting a PIP to address members receiving preventive dental care at least twice per year. The PIP employs two (2) performance indicators: percentage of members who received at least one (1) preventive dental service during the measurement year (two age strata: 1–20 years and 21+ years), and percentage of members who received at least two (2) preventive dental services 6 months apart during the measurement year (age strata: 1–20 years and 21+ years). The baseline period for the PIP was 1/1/18–12/31/18. The baseline rates for the percentage of members who received at least one (1) preventive dental service for the members aged 1–20 and 21+ were 54.6% and 21.0%, respectively. MCNA aims to increase this rate to 58.6% for the 1–20 years age group and to 23.0% for the 21+ age group. The baseline rates for the percentage of members who received at least two (2) preventive dental services for members aged 1–20 and 21+ were 27.1% and 8.4%, respectively. MCNA aims to increase this rate to 30.1% for the 1–20 years age group and to 10.4% for the 21+ age group.

Analysis of performance indicator data will be available in the reporting year (RY) 2020 annual technical report.

## Compliance Review

MCNA received a “full compliance” designation for Subcontracting, Quality Management, and Provider Services, and a “substantial compliance” designation for Grievances and Appeals, Utilization Management, and Member Services and Education. MCNA received a “minimal compliance” designation for one element under Member Services and Education:

- Of the 38 standards/substandards reviewed for Grievances and Appeals, 34 standards/substandards were fully compliant and four (4) were substantially compliant. Three substantially compliant standards/substandards were related to quality. The following details findings from the review of the substantially compliant standards:
  - Ensure that there is only one level of appeal for members. This requirement is not explicitly stated within the dental benefits program manager (DBPM)’s policies and procedures.
  - 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. This requirement was partially addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2; however, there is an opportunity to make this policy more transparent.
  - The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution. This language was not clear in member letters.

- Of the 51 standards/substandards reviewed for Member Services and Education, 47 were fully compliant, three (3) 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

- The extent to which, and how, after-hours and emergency coverage are provided, including that, when necessary, members should refer to their Heritage Health member information for emergencies relating to the member’s physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM. There is only reference made to Heritage Health in the context of prescription coverage.
- The member handbook should contain information about member co-payments; however, there is no language pertaining to co-payments.
- The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). The DBPM’s website provided neither an accessibility feature for members with visual impairments nor the capability for bi-directional communications.

### Minimally Compliant Standard

- Any additional information that is available upon request, including but not limited to: a. structure and operation of the DBPM, b. the DBPM dentist incentive plan (42 CFR 438.6), c. DBPM service utilization policies, d. how to report alleged marketing violations to Medicaid and Long-Term Care (MLTC), and e. reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state. This requirement is addressed on page 34 of the member handbook for sub-element d only.

- Of the 48 standards/substandards reviewed for Utilization Management, 45 standards/substandards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. The following details findings from the review of the substantially compliant standard for the domain of quality:
  - As part of the DBPM appeal procedures, the DBPM must include an informal reconsideration process that allows the member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. None (0) of the 10 files reviewed included information about informal reconsideration in the notice of action letter.

In the domain of quality, IPRO recommends that MCNA:

- Incorporate language pertaining to only one level of member appeal into MCNA’s policies and procedures and in their member handbook and provider manual.
- Add language in Policy 13.100 Grievances and Appeals Department Overview to reflect contractual requirement IV.H.1.b.3, that the individual addressing the member’s grievance must be a health care professional with clinical

expertise in treating the member's condition or disease if any of the following apply: the denial of service is based on lack of medical necessity; because of the member's medical condition, the grievance requires expedited resolution; or the grievance or appeal involves clinical issues.

- Add language to the member handbook that the member should contact their Heritage Health Plan for information regarding emergencies relating to the member's physical and behavioral services in addition to the pharmaceutical services, as those benefits are not reimbursed by the DBPM.
- Add language to the member handbook pertaining to co-payments.
- Add an easily accessible feature to MCNA's website to accommodate the visually impaired who have difficulty reading. It is also recommended that a bi-directional communication capability be considered for members to obtain real-time answers to questions.
- Add additional information to the member handbook to ensure members are aware that they can request information related to the structure/operation of the DBPM, the dentist incentive plan, service utilization policies, and reports of transactions between the DBPM and parties of interest.

## Timeliness

The timeliness domain includes findings from two (2) of the seven (7) compliance domains: Utilization Management, and Grievances and Appeals.

### Compliance Review

- Of the 38 standards/substandards reviewed for Grievances and Appeals, 34 standards/substandards were fully compliant and four (4) were substantially compliant. One substantially compliant standard/substandard was related to timeliness. The following details findings from the review of the substantially compliant standard:
  - The DBPM must acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.
- Of the 48 standards/substandards reviewed for Utilization Management, 45 standards/substandards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. The following details findings from the review of the substantially compliant standard for the domain of timeliness:
  - The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than 14 calendar days following receipt of the request for service unless an extension is requested. In no instance must any determination of standard service authorization be made later than 25 calendar days from receipt of the request.

In the domain of timeliness, IPRO recommends that MCNA:

- Remove the language related to a state fair hearing from the grievance acknowledgement letter, since state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).
- Clarify the language in the acknowledgement letter as to how state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).
- Develop a policy that clearly states that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard versus extended).
- Include information about informal reconsideration in the notice of action to the member.

## Access

The access domain includes findings from one (1) of the seven (7) compliance domains: Provider Network.

### Compliance Review

MCNA received a "full compliance" designation for Provider Network.

There are no recommendations in the domain of access at this time.

## 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 (MLTC). 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 (MMC) program for physical health (PH), behavioral health (BH), and pharmacy services statewide.

The Nebraska 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 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 MCOs to each provide physical health care, behavioral health care, and pharmacy services for their Medicaid and Children’s Health Insurance Program (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. Further, NE DHHS contracted with one dental benefits manager, MCNA, which started operations in October 2017, across all 93 counties.

Table 1: Nebraska MCEs and Counties

MCEs	Counties
<ul style="list-style-type: none"> <li>• Nebraska Total Care</li> <li>• UnitedHealthcare Community Plan of Nebraska</li> <li>• WellCare Health Plan of Nebraska</li> <li>• Managed Care of North America (MCNA) Dental</li> </ul>	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

MCE: managed care entity.

Medicaid populations who are mandated to participate in the Nebraska MMC 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, 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; and
9. Members eligible during a period of presumptive eligibility.

DHHS 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, and
6. Pharmacy benefit management services.

The MMC 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 across the four (4) MCEs as of December 2018.

**Table 2: Medicaid Managed Care Enrollment by MCE as of December 2018**

MCE	MMC Enrollment
MCNA Dental	240,677
Nebraska Total Care	77,155
UnitedHealthcare Community Plan of Nebraska	77,403
WellCare Health Plan of Nebraska	80,093

MCE: managed care entity; MMC: Medicaid managed care; MCNA: Managed Care of North America.

## Nebraska Quality Goals and Objectives

NE DHHS developed the MMC 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 (PIPs) 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

Over the course of 2018, IPRO conducted a compliance monitoring site visit, validation of performance measures, and validation of PIPs. 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–C** and address:

- Objectives for conducting the activity,
- Technical methods of data collection,
- Descriptions of data obtained, and
- 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

As shown in **Table 3**, four MCEs comprised Nebraska’s MMC program during 2018:

- Managed Care of North America Dental (MCNA) is a Medicaid DBPM that serves the entire state of Nebraska.
- 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. UnitedHealthcare Community Plan serves the entire state of Nebraska.
- WellCare Health Plan of Nebraska (WellCare) is a Medicaid MCO operated by WellCare Health Plans, Inc. WellCare serves the entire state of Nebraska.

Table 3: Corporate Profiles

Field	MCNA	NTC	UHCCP	WellCare
Type of organization	PAHP	HMO	HMO	HMO
Year operational	2017	2017	Prior to 2002	2017
Total Medicaid enrollment as of 12/2018	240,677	77,155	77,403	80,093
NCQA Medicaid accreditation status		Interim	Commendable	Accredited
NCQA National Medicaid ranking		Unavailable <sup>1</sup>	4.0	Unavailable <sup>1</sup>
URAC Medicaid accreditation status	Fully accredited			

MCNA: Managed Care of North America; NTC: Nebraska Total Care; UHCCP: UnitedHealthcare Community Plan; PAHP: prepaid ambulatory health plan; HMO: health maintenance organization; NCQA: National Committee for Quality Assurance; URAC: Utilization Review Accreditation Committee.

<sup>1</sup> Ratings unavailable due to insufficient data per NCQA Health Plan Rating results (<http://healthinsuranceratings.ncqa.org/>).

# 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 MCEs' 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, HEDIS Performance, and Validation of Performance Improvement Projects).

## Compliance Monitoring

This subpart of the report presents the results of the review by IPRO of the MCEs' compliance with regulatory standards and contract requirements for September 1, 2017–March 31, 2018. The review is based on information derived from IPRO's conduct of the annual regulatory compliance review, which took place in May 2018. 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.
- **Provider Services**—The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.
- **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 MCE 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 of member services and education 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 of quality management 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; PIPs; HEDIS final audit report (FAR); 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 of utilization management 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, MCE program reports on appeals and grievances, QI committee minutes, and staff interviews.

**Table 4** displays the 2018 compliance review designations for each MCE.

Table 4: Summary of 2018 Compliance Review Findings (Measurement Period 9/1/17–3/31/18)

Compliance Domain	MCNA	NTC	UHCCP	WellCare	Performance Domain(s)
Care Management	N/A	Full	Full	Substantial	Access
Provider Network	Full	Substantial	Full	Substantial	Access
Provider Services	Full	Substantial	Full	Substantial	Quality
Subcontracting	Full	Full	Full	Full	Quality
Member Services and Education	Substantial	Substantial	Substantial	Substantial	Quality
Quality Management	Full	Substantial	Full	Substantial	Quality
Utilization Management	Substantial	Substantial	Full	Substantial	Quality and Timeliness
Grievances and Appeals	Substantial	Substantial	Substantial	Substantial	Quality and Timeliness

MCNA: Managed Care of North America; NTC: Nebraska Total Care; UHCCP: UnitedHealthcare Community Plan of Nebraska.

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

## MCNA

### 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 42 standards/substandards were reviewed; all were fully compliant.

### Provider Services

The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.

A total of three (3) 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 four (4) standards/substandards were reviewed; all were fully compliant.

### Member Services and Education

The evaluation of member services and education 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 51 standards/substandards were reviewed; 47 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. Member services and education substantially compliant standards/substandards are presented in **Table 5**. Member services and education minimally compliant standards/substandards are presented in **Table 6**.

Table 5: MCNA Member Services and Education – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<p>19. The extent to which, and how, after-hours and emergency coverage are provided, including:</p> <ul style="list-style-type: none"> <li>a. What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c).</li> <li>b. That prior authorization is not required for emergency services.</li> <li>c. The process and procedures for obtaining emergency services, including use of the 911 telephone system.</li> <li>d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.</li> <li>e. That, when necessary, members should refer to their Heritage Health member information for emergencies relating to the member’s physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM.</li> </ul>	<p>Requirements a–d are addressed on page 19 of the member handbook. Requirement e is not fully addressed; there is only reference made to Heritage Health in the context of prescription coverage.</p> <p><b>Recommendation:</b> The member handbook should contain language that the member should contact their Heritage Health Plan for information regarding emergencies relating to the member’s physical and behavioral services in addition to the pharmaceutical services, as those benefits are not reimbursed by the DBPM.</p>	<p>Content was added on page 21 of the member handbook.</p>
<p>23. Information about member co-payments.</p>	<p>This requirement is partially addressed on page 10 of the member handbook, wherein reference is made to services that are not covered, as well as how members under age 21 do not have to pay for medically necessary dental services. The handbook further specifies that dental coverage is limited to \$750 per fiscal year for individuals aged 21 years and older.</p> <p><b>Recommendation:</b> Language pertaining to co-payments should be added in the member handbook.</p>	<p>There are no co-payments. This language can be found on page 11 of the member handbook.</p>
<p><b>Member website:</b> The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses).</p>	<p>All the requirements are addressed in the website development and maintenance policy. The DBPM’s website is accessible from a mobile device. The privacy policies are all visible and accessible at the bottom of the home page, as well as the TTY (hearing-impaired) number. The DBPM has a mobile application named MyMCNA for both Android and Apple device users that can be downloaded for</p>	<p>N/A (no response received).</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<p>The DBPM website must include general and up-to-date information about the Nebraska Medicaid program and the DBPM.</p> <p>The DBPM must remain compliant with applicable privacy and security requirements (including, but not limited to, HIPAA) when providing member eligibility or member identification information on its website.</p> <p>The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the act sets for people with visual impairments and disabilities that make usability a concern.</p> <p>The DBPM website must follow all written marketing guidelines included in Section IV G - Member Services and Education.</p> <p>Use of proprietary items that would require use of a specific browser or other interface is not allowed.</p>	<p>free for all members. In addition, the DBPM has utilized social media such as Facebook, Twitter, and YouTube as another means of communication and to provide updates, information, and education to members in both their pediatric and adult populations.</p> <p>The DBPM’s website did not provide an accessibility feature for members with visual impairments, nor the capability for bi-directional communications. The DBPM has discussed that most of their members call the office if they have questions. Some members also email MCNA. If the email is submitted during off-hours, the DBPM will respond the next business day.</p> <p><b>Recommendation:</b> An easily accessible feature should be added to MCNA’s website to accommodate the visually impaired who are not able or have difficulty reading regular print (an onsite demonstration showed how the member can enlarge font by pressing “control” and “+” at the same time on their keypads; however, there is an opportunity to provide this instruction on the website, in the event members are not well-versed in how to manipulate font size digitally). It is also recommended that a bi-directional communication capability be considered for members to obtain real-time answers to questions.</p>	

MCNA: Managed Care of North America; CFR: code of federal regulations; DBPM: dental benefits program manager; HIPAA: Health Insurance Portability and Accountability Act; TTY: text telephone; MCNA: Managed Care of North America; N/A: not applicable.

Table 6: MCNA Member Services and Education – Minimally Compliant Standards/Substandards

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<p>29. Any additional information that is available upon request, including but not limited to:</p> <ul style="list-style-type: none"> <li>a. The structure and operation of the DBPM.</li> <li>b. The DBPM dentist incentive plan (42 CFR 438.6).</li> </ul>	<p>This requirement is addressed on page 34 of the member handbook for sub-element d only.</p> <p><b>Recommendation:</b> All the sub-elements of this requirement should be included in the member handbook to ensure</p>	<p>The language was added to the member handbook on page 36.</p>

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<ul style="list-style-type: none"> <li>c. The DBPM service utilization policies.</li> <li>d. How to report alleged marketing violations to MLTC.</li> <li>e. Reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state.</li> </ul>	<p>members are aware that they can request information related to the structure/operation of the DBPM, the dentist incentive plan, service utilization policies, and reports of transactions between the DBPM and parties of interest.</p>	

MCNA: Managed Care of North America; DBPM: dental benefits program manager; CFR: code of federal regulations; MLTC: Medicaid and Long-Term Care.

### Quality Management

The evaluation of quality management 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; PIPs; 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 28 standards/substandards were reviewed; 20 were fully compliant and eight (8) were deemed not applicable.

### Utilization Management

The evaluation of utilization management includes, but is not limited to, review of: policies and procedures for Utilization Management (UM), UM Program Description, UM Program Evaluation, UM activities, and file review of denials.

A total of 48 standards/substandards were reviewed; 45 were fully compliant, two (2) were substantially compliant, and one (1) was deemed not applicable. Utilization management substantially compliant standards/substandards are presented in **Table 7**.

**Table 7: MCNA Utilization Management– Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<p><b>Timing of Service Authorization Decisions Standard Service Authorization:</b></p> <ul style="list-style-type: none"> <li>1. The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested.</li> <li>2. An extension may be granted for an</li> </ul>	<p>This requirement is addressed in the service authorizations including retrospective reviews policy on page 3 and in the UM program description on pages 12 and 19. Although the service authorization including retrospective reviews policy clearly outlines the fourteen (14)-calendar-day requirement for standard service authorization and the additional fourteen (14) calendar days for the extension, neither this policy nor any other policy submitted by the plan indicated that the maximum cap for a service authorization to reach a determination is twenty-five (25) calendar days.</p> <p>Ten (10) of 10 UM denial files were</p>	<p>The recommended update was completed after the onsite comments were received from the EQRO. The policy was updated and approved by the UM Committee and QIC.</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
<p>additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the DBPM justifies to MLTC a need for additional information and the extension is in the member’s best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request.</p> <p>If the DBPM extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The DBPM must issue and carry out its determination as expeditiously as the member’s health condition requires, but no later than the date the extension expires.</p>	<p>reviewed and all were standard service authorizations. Of these, all 10 met the requirement of determination within fourteen (14) calendar days. Nine (9) out of 10 files were given a determination within two (2) business days, which shows that the plan exceeded the requirement of 80% of standard service authorizations getting a determination within two (2) days.</p> <p><b>Recommendation:</b> The policy should clearly state that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard versus extended). File review evidences that the DBPM is indeed meeting this requirement; however, policies must also include this requirement.</p>	
<p><b>Informal Reconsideration:</b></p> <ol style="list-style-type: none"> <li>1. As part of the DBPM appeal procedures, the DBPM must include an informal reconsideration process that allows the member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.</li> <li>2. In a case involving an initial determination, the DBPM must provide the member or a provider acting on behalf of the member and with the member’s written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.</li> <li>3. The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM’s dentist authorized to make adverse determinations or a clinical peer designated by the dental director if</li> </ol>	<p>This requirement is addressed in the member handbook on page 30, the provider manual on page 59, and in the informal reconsideration process policy.</p> <p>Ten (10) of 10 files were reviewed and none (0) had an informal reconsideration; therefore, this requirement was not applicable for the files reviewed. However, since informal reconsideration is a potential immediate next step after an adverse determination, the notice of action letters should include information about informal reconsideration. None (0) of the 10 files reviewed included information about informal reconsideration in the notice of action letter.</p> <p><b>Recommendation:</b> The notice of action to the member and the provider should include information about informal reconsideration.</p>	<p>Informational denial information will be added to the letter and submitted to MLTC for approval.</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
the dentist who made the adverse determination cannot be available within one (1) business day. The informal reconsideration will in no way extend the 30-day required timeframe for a notice of appeal resolution.		

MCNA: Managed Care of North America; DBPM: dental benefits program manager; MLTC: Medicaid and Long-Term Care; UM: utilization management; EQRO: external quality review organization; QIC: Quality Improvement Committee.

## 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 38 standards/substandards were reviewed; 34 standards/substandards were fully compliant and four (4) were substantially compliant. Grievances and appeals substantially compliant standards/substandards are presented in **Table 8**.

Table 8: MCNA Utilization Management– Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	<p>This requirement is addressed in MCNA’s formal grievance procedure policy, and Policy 13.200 Member Appeals.</p> <p>Four (4) grievance files were available for review during the measurement period. Ten (10) appeal files were reviewed. All files contained evidence of this requirement.</p> <p>It was suggested onsite that the DBPM include the nature of the grievance in the acknowledgement letter, in the event the member has multiple grievances, for instance. Further, the language related to a state fair hearing should be removed from the grievance acknowledgement letter, since state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).</p> <p><b>Recommendation:</b> Language should be clarified as to how state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days). This may mean additionally that the definitions of appeal and grievance, and the processes for both, are</p>	The recommended update to remove the state fair hearing language from the grievance acknowledgement letter has been completed.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	<p>clearly defined in writing in the associated policies and procedures for members, providers, and for MCNA staff to ensure that all parties understand the differences between the processes, how to access the process, and how to manage the process. It is imperative that any confusion on this process is clarified among MCNA members, providers, and staff.</p>	
<p>2. Ensure that there is only one level of appeal for members.</p>	<p>This requirement is evidenced within MCNA’s practices, however not explicitly stated within the DBPM’s policies and procedures.</p> <p><b>Recommendation:</b> Language pertaining to only one level of member appeal should be incorporated into MCNA’s policies and procedures and in their member handbook and provider manual.</p>	<p>This recommendation was addressed by the addition of appropriate language pertaining to only one level of member appeal to policies 13.100, 13.200, and 13.203. The revised member handbook was submitted and approved by the MLTC on 6/11/2018. The provider manual was also updated with the recommended revision. The policies and provider manual will be submitted to MLTC for review and approval.</p>
<p>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. The individual addressing a member’s grievance must be a health care professional with clinical expertise in treating the member’s condition or disease if any of the following apply:</p> <ol style="list-style-type: none"> <li>1. The denial of service is based on lack of medical necessity.</li> <li>2. Because of the member’s medical condition, the grievance requires expedited resolution.</li> <li>3. The grievance or appeal involves clinical issues.</li> </ol>	<p>This requirement is addressed in Policy 13.200 Member Appeals on pages 6 and 7.</p> <p>This requirement is partially addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2, as follows: “Fairness in the review process based on a requirement that internal reviewers have the necessary and relevant knowledge and expertise to render a decision regarding an appeal or grievance, have not been involved in the initial decision, and have no financial interest in the resolution of the decision.” Necessary and relevant knowledge and expertise implies clinical knowledge; however, there is an opportunity to make more transparent.</p> <p>Ten (10) of 10 appeal files met this requirement (demonstrating that the individual completing the appeal review was not the same individual involved in the initial denial decision, and was an appropriate health care professional with expertise in treating the member’s condition). It should be noted that within one (1) appeal file, the resolution letter states that the appeal reviewer is a pediatric dentist; however, the</p>	<p>The recommendation to update Policy 13.100 with contractual requirement IV.H.1.b.3 has been completed. The policy will be submitted to MLTC for review and approval.</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	<p>appeal reviewer in the case file is listed as a general dentist.</p> <p>Three (3) of four (4) grievance files were not applicable (as they did not pertain to a medical issue). One (1) applicable file met this requirement (demonstrating that the individual addressing member’s grievance was a health care professional with appropriate expertise in treating their condition).</p> <p><b>Recommendation:</b> The language in Policy 13.100 Grievances and Appeals Department Overview should reflect contractual requirement IV.H.1.b.3, that the individual addressing the member’s grievance must be a health care professional with clinical expertise in treating the member’s condition or disease if any of the following apply: the denial of service is based on lack of medical necessity; because of the member’s medical condition, the grievance requires expedited resolution; or the grievance or appeal involves clinical issues.</p>	
<p>The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.</p>	<p>This requirement is addressed in Policy 13.200 Member Appeals on page 3, and in Policy 13.203 Expedited Appeals on page 2.</p> <p>Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals. It should be noted that there were two (2) requests for expedited resolution that were not processed as such, given the criterion for expedited resolution was not met.</p> <p>There was a recommendation made onsite that included a change to the way in which the acknowledgement letter reads in these cases, since it states the DBPM will not approve the member’s request, but does not then state “for an expedited (or fast) decision.” This may lead to confusion if the member does not carefully read the remainder of the letter, which states the “clinical reviewer determined that the request does not meet the rules for a fast appeal” and that they will “give the member a decision in writing in 30 days.” The initial reference to MCNA not approving the request</p>	<p>The recommendation to revise the expedited appeal acknowledgment letter with required language has been completed.</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	<p>does not apply to the appeal request, but rather the expedited portion of it.</p> <p><b>Recommendation:</b> MCNA should revise the expedited appeal acknowledgment letter in cases where the request does not meet expedited appeal criteria; the DBPM should state that they will not approve the member’s request <u>for an expedited (or fast) decision</u>. Adding this additional language (<u>for an expedited (or fast) decision</u>) will help avoid confusion and ensure clarity for the member that their appeal was not necessarily denied, but rather their request for an expedited resolution was.</p>	

MCNA: Managed Care of North America; DBPM: dental benefits program manager; MLTC: Medicaid and Long-Term Care.

### 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 59 standards/substandards were reviewed; all were fully compliant.

### 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 65 standards/substandards were reviewed; 61 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. Provider network substantially compliant standards/substandards are presented in **Table 9**, and minimally compliant standards/substandards are presented in **Table 10**.

Table 9: NTC Provider Network – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Mainstreaming of members	<p>The MCO has a policy (NE.CONT.03) regarding non-discrimination of Indians; however, this policy does not include all state contract requirements. During the onsite review, the MCO provided additional evidence of addressing nondiscrimination in the PPA, as well as in the welcome kit to new members. However, evidence of all state contract requirements could not be found in the provider manual or member handbook.</p>	<p>NTC agrees with findings. While NE.CONT.03 is specific to the Indian population, NE.PRCN.05, also supplied, speaks to nondiscrimination across the entire network.</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
	<p><b>Recommendation:</b> NTC should update their policy to include each of the contract requirements. Additionally, the MCO should update the provider manual and member handbook to include the contract requirements.</p>	
<p>The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding behavioral health conditions.</p>	<p>The MCO's network adequacy policy (NE_CONT-01) describes its behavioral health network; however, the policy does not include the behavioral health conditions specified in the standard.</p> <p><b>Recommendation:</b> The MCO should update the policy to specify the behavioral health conditions described in the state contract.</p>	<p>NTC agrees with findings. NE.CONT.01 has been updated to include this language.</p>
<p>Wait times for scheduled appointments should not routinely exceed 45 minutes.</p>	<p>The MCO's NE PRVR 06 policy includes the 45-minute wait time standard. The provider contract (page 24 – NTC PPA) states 45 minutes; however, the provider manual (page 18) states one (1) hour. Similarly, the member handbook states one (1) hour as well.</p> <p><b>Recommendation:</b> The MCO should update the provider manual and member handbook to reflect the 45-minute requirement.</p>	<p>NTC agrees with findings.</p>

MCO: managed care organization; NTC: Nebraska Total Care; PPA: Participating provider agreement.

Table 10: NTC Provider Network – Minimally Compliant Standards/Substandards

Minimally Compliant Standard	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>The MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider.</p>	<p>Language not limiting providers from contracting with another MCO could not be located in policy NE.CONT.01 or in the provider contract.</p> <p><b>Recommendation:</b> NTC should update policy NE.CONT.01 and the provider contract to include language to meet this requirement.</p>	<p>NTC agrees with findings.</p>

MCO: managed care organization; NTC: Nebraska Total Care; PPA: participating provider agreement.

## Provider Services

The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.

A total of four (4) standards/substandards were reviewed; one (1) was fully compliant and three (3) were substantially compliant. Provider services substantially compliant standards/substandards are presented in **Table 11**.

Table 11: NTC Provider Services – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.</p>	<p>As it is currently written, the provider complaint process lacks clarity and timeframes are inconsistently described. For example, element 2, Provider Complaints, states that the provider will receive written resolution of the complaint from the Claims department within 30 business days of the receipt of the complaint. Element 3, Process for Submitting a Provider Grievance/Complaint, states a resolution timeframe not to exceed 90 calendar days. The NTC tracking log report notes a 60-day turnaround time. It is also noted that the provider manual includes a 90-day resolution timeframe. The MCO clarified that resolution timeframe for claims adjustment/claim complaints is 30 days and that the resolution timeframe for non-claims complaints is 60 days. The 90-day timeframe is applicable to grievances filed on behalf of a member.</p> <p>The policy/procedure for provider complaints should also distinguish between a provider complaint and a provider grievance.</p> <p><b>Recommendation:</b> NTC should develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request, and for resolution.</p> <p>The criteria used to define a provider complaint versus a provider grievance should be documented, including how each is tracked and reported. The provider</p>	<p>NTC agrees with findings. A revision to PR.VR.03 was completed on 6/20/2018 and approved by the health plan that took into account the feedback from IPRO and made it more clear and explicit to provider complaints. Additionally, updated provider grievance and appeal letters were created to accompany the policy.</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
	<p>complaint policy/procedure should also describe how complaints from out-of-network providers are handled.</p>	
<p>Policies and procedures must include a description of how providers may file a complaint, and how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf.</p>	<p>The provider grievance acknowledgment letter addresses member grievances, not provider complaints. Likewise, the template grievance inquiry letter is related to member grievances, not provider complaints. NTC explained that these templates are used for both member and provider grievances. The templates apply to member grievances filed by members or providers filing on behalf of a member, but not for provider complaints. NTC should develop separate template letters for each type: provider complaint, provider grievance, member grievance, and grievance filed by the provider on the member's behalf.</p> <p>The template provider grievance resolution letter includes language that, if not satisfied, a provider can request a second review by MCO QM staff. This second-level of review is not addressed in other documents provided, including the policy/procedure, provider manual, and website.</p> <p><b>Recommendation:</b> NTC should develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request, and for resolution.</p> <p>NTC should develop separate template letters for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances.</p> <p>NTC should confirm with MLTC the circumstances upon which providers may file a complaint directly with MLTC for those issues that are not a MCO function and document this in policy.</p> <p>NTC should maintain a description of how</p>	<p>NTC agrees with findings. A revision to PR.VR.03 was completed on 6/20/2018 and approved by the health plan that took into account the feedback from IPRO and made it more clear and explicit to provider complaints. Additionally, updated provider grievance and appeal letters were created to accompany the policy.</p> <p>NTC has also completed a revised provider manual for 2018 with updates.</p> <p>Provider services training protocols and documentation have been identified based on feedback.</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
	<p>provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf and provide evidence of this training during future compliance reviews.</p> <p>Language found within the provider grievance resolution letter template (regarding a second review by MCO QM staff if provider not satisfied with first review) should also be included in the MCO's policy/procedure, provider manual, and website.</p>	
<p>The MCO must include a description of the provider complaint system in its provider handbook and on its provider website.</p>	<p>The provider manual is included on the NTC website. The website also includes a discrete section titled Grievance Process. Both are included under the heading of Provider Resources.</p> <p>The provider manual includes the provider's right to make a complaint. Under a section titled Member Grievances, both member grievances and provider complaints are described. It is noted that the process is the same for both.</p> <p>The discrete section titled Grievance Process refers to member grievances only.</p> <p><b>Recommendation:</b> The NTC provider manual and website should include separate descriptions and instructions for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances and appeals. NTC should ensure consistency across policies/procedures, the provider manual, and the website.</p>	<p>NTC agrees with findings. The MCO has completed a revised provider manual for 2018 with updates and will ensure posting of relevant material to website upon the revised provider's approval by MLTC.</p>

MCO: managed care organization; NTC: Nebraska Total Care; IPRO: Island Peer Review Organization; QM: quality management; MLTC: Medicaid and Long-Term Care.

### 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; all were fully compliant.

### Member Services and Education

The evaluation of member services and education includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, primary care provider (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 61 standards/substandards were reviewed; 54 were fully compliant, four (4) were substantially compliant, and three (3) were minimally compliant. Member services and education substantially compliant standards/substandards are presented in **Table 12**. Member services and education minimally compliant standards/substandards are presented in **Table 13**.

**Table 12: NTC Member Services and Education – Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Indian health protections	<p>While NTC provided IPRO with what seems like a map of Nebraska’s I/T/U provider network across all counties, the map is difficult to interpret without a key. IPRO requested a key for the map on multiple occasions. Onsite, the MCO stated a key would be uploaded to the FTP site; however, it was not uploaded.</p> <p><b>Recommendation:</b> The MCO should provide a map key or explanation of the I/T/U provider coverage map on the next compliance review so that it can be interpreted accurately.</p>	<p>NTC disagrees with findings; the legend to the map was provided in a separate document titled Attachment 3 – Nebraska Counties Classification, which is located under the Provider Network folder.</p> <p>IPRO determined there was no change in review determination. The map titled “Attachment 3—Nebraska Counties Classification” depicts the distribution of rural, frontier, and urban counties throughout the state of Nebraska, but does not depict the adequacy of I/T/U provider coverage in Nebraska.</p>
New member materials must describe the MCO’s website, the materials that the members can find on the website, and how to obtain written materials if the member does not have access to the website.	<p>The verbiage for this requirement is not presented on the member info sheet that was provided, titled “LotA_WL_NewMember-2048637-1_Proof1.” There is only verbiage explaining that if the member has questions, they can call member services. Information about the NTC member website and what is on the website is found on page 19 of the member handbook; however, there is no verbiage which explains how the member can obtain written materials if they do not have access to the website.</p> <p><b>Recommendation:</b> The MCO should provide members with information on how to obtain written materials if the member does not have access to their website.</p>	<p>NTC agrees with findings. The member handbook has been updated to provide additional options to members on how they can obtain information besides the NTC site. NTC is awaiting MLTC approval of the member handbook.</p>
All written materials must be clearly legible with a	The MCO provided examples of written materials such as: member handbook,	NTC agrees with findings. The MCO has updated the policy and procedure manual

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>minimum font size of twelve (12)-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.</p>	<p>statement of non-discrimination, member brochure, and annual member mailing. These are all clearly legible on the computer screen; however, it is difficult to determine the font size, as these documents are in PDF format and screenshots of the website. This requirement is not included in the policy/procedure provided.</p> <p><b>Recommendation:</b> NTC should specify the minimum font size of member materials in a policy/procedure, and provide materials that are in a Word document format for the next compliance review.</p>	<p>of the required twelve (12)-point font size for all member materials given.</p>
<p>The MCO's physician incentive plan, as well as reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state, are available upon request.</p>	<p>There was no verbiage in the member handbook stating the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state.</p> <p><b>Recommendation:</b> The MCO should add verbiage to the member handbook which states the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state.</p>	<p>NTC agrees with findings.</p>

NTC: Nebraska Total Care; IPRO: Island Peer Review Organization; I/T/U: Indian health services, tribal health providers, and urban Indian health providers; MCO: managed care organization; MLTC: Medicaid and Long-Term Care; ID: identification.

Table 13: NTC Member Services and Education – Minimally Compliant Standards/Substandards

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>A minimum of once a year, the MCO must notify members of the option to receive the member handbook and the provider directory in either electronic or paper format.</p>	<p>The MCO provided the annual member mailing as documentation for this requirement. The mailing does not have verbiage that describes to the member that they have the option to receive the member handbook and provider directory in paper or electronic format. This information was also not found in the member handbook.</p> <p><b>Recommendation:</b> The MCO should provide members with written notification at least once a year that states that they can receive the member handbook and</p>	<p>NTC agrees with findings. Notifications will be sent out to all members via mail at least annually.</p>

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
	provider directory in paper or electronic format.	
A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.	The MCO provided the annual member mailing as documentation for this requirement. The mailing does not have verbiage that describes to the member that they have the right to disenrollment from the MCO.  <b>Recommendation:</b> The MCO, at a minimum of annually, should provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.	NTC agrees with findings. Notifications will be sent out to all members via mail at least annually.
A minimum of annually, the MCO will inform all members of their right to request an updated member handbook and updated provider directory at no cost to the member.	The MCO provided the annual member mailing as documentation for this requirement. The mailing does not have verbiage that describes to the member that they have the option to receive the member handbook and provider directory at no cost to the member.  <b>Recommendation:</b> The MCO should inform members of the right to obtain the member handbook and provider directory at no cost.	NTC agrees with findings. Notifications will be sent out to all members via mail at least annually.

MCO: managed care organization; NTC: Nebraska Total Care.

## Quality Management

The evaluation of quality management 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; PIPs; HEDIS final audit report (FAR; 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 58 standards/substandards were reviewed; 56 standards/substandards were fully compliant, one (1) was substantially compliant, and one (1) was not applicable. Quality management substantially compliant standards/substandards are presented in **Table 14**.

**Table 14: NTC Quality Management – Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
The MCO must report on the activities of the MCO's MAC semiannually. This report must include the membership of the committee (name, address, and organization)	This requirement is addressed in the MAC MLTC Report 12312017; however, name, address, and organization represented were not evident in this report, and not included in the 10/25/17 report or the 1/25/18 MAC minutes.	NTC agrees with findings.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
represented).	<b>Recommendation:</b> The MCO should include the name, address, and organization represented for each member on the committee.	

MCO: managed care organization; MAC: Member Advisory Committee; MLTC: Medicaid and Long-Term Care; NTC: Nebraska Total Care.

### Utilization Management

The evaluation of utilization management 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 65 standards/substandards were reviewed; 63 were fully compliant and two (2) were substantially compliant. Utilization management substantially compliant standards/substandards are presented in **Table 15**.

Table 15: NTC Utilization Management – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) 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.	A policy reading provided no finding of the wording changes to incorporate race/ ethnicity as per MCO response from last year's findings.  <b>Recommendation:</b> The MCO should add the wording from the state contract related to monitoring providers' utilization of services by race, ethnicity, gender, and age.	NTC agrees with the findings. Policy NE.UM.01.03 was revised to reflect the language: Monitoring includes services at all levels of care, and utilization of services by race, ethnicity, gender, and age. This policy will be submitted upon next IPRO review.
The MCO must give notice as expeditiously as the member's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service.	One (1) of 10 files reviewed exceeded the 14-day timeframe.  <b>Recommendation:</b> The MCO can improve its internal controls such that timeliness standards are met.	MCO agrees with findings and has improved internal controls to assure compliance with timeliness.

MCO: managed care organization; NTC: Nebraska Total Care.

### 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 39 standards/substandards were reviewed; 35 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. Grievances and appeals substantially compliant standards/substandards are presented in **Table 16**. Grievances and appeals minimally compliant standards/substandards are presented in **Table 17**.

Table 16: NTC Grievances and Appeals – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>The MCO must acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.</p>	<p>Sixteen (16) of 20 grievance files contained evidence of a timely acknowledgement letter; the remaining four (4) grievance files contained acknowledgement letters that were dated past 10 calendar days after the request was received.</p> <p><b>Recommendation:</b> The MCO should ensure timely acknowledgment letters are provided for all members who file a grievance or appeal.</p>	<p>NTC agrees with findings.</p>
<p>The MCO must ensure that there is only one level of appeal for members.</p>	<p>There is no language in the grievance policy/procedure, member handbook, or provider manual which implies MCO must “Ensure that there is only one level of appeal for members” in the documentation provided.</p> <p><b>Recommendation:</b> The MCO should include the verbiage that there is only one level of appeal for members in the applicable policies, provider manual, and member handbook.</p>	<p>NTC agrees with findings. NTC has added the wording of “One level of appeal” to all documentation, including member handbook, provider manual, website, and policy.</p>
<p>In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.</p>	<p>Nine (9) of out 10 appeals files were not applicable, as they were not expedited appeals.</p> <p>The one (1) applicable file reviewed did not contain evidence that the MCO provided the member with verbal notice of resolution.</p> <p><b>Recommendation:</b> Verbal notice of resolution of expedited appeals should be provided. Further, this verbal notice should be documented in the case notes for each expedited appeal.</p>	<p>NTC agrees with findings. Computer documentation has a required field for verbal notification. Monitoring/audits performed to ensure compliance.</p>

MCO: managed care organization; NTC: Nebraska Total Care.

Table 17: NTC Grievances and Appeals – Minimally Compliant Standards/Substandards

Minimally Compliant Standard/Substandard	Findings and Recommendations for Improvement	NTC Response and Action Plan
<p>A member may file a grievance with the MCO or the state at any time.</p>	<p>There was no language found in the documentation provided that states, “A member can file a grievance with the MCO or state <u>at any time.</u>”</p>	<p>NTC agrees with findings. NTC has added the wording “anytime” to all documentation including member handbook, provider manual, website, and policy.</p>

	<b>Recommendation:</b> The MCO should add this language to their member handbook, all applicable policies, and to their website.	
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MCO: managed care organization; NTC: Nebraska Total Care.

### 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 59 standards/substandards were reviewed; all were fully compliant.

### 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 65 standards/substandards were reviewed; all were fully compliant.

### Provider Services

The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.

A total of four (4) 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 four (4) standards/substandards were reviewed; all were fully compliant.

### Member Services and Education

The evaluation of member services and education 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 61 standards/substandards were reviewed; 60 were fully compliant and one (1) was substantially compliant. Member services and education substantially compliant standards/substandards are presented in **Table 18**.

Table 18: UHCCP Member Services and Education – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
<p><b>Notice to Members of Provider Termination:</b> The MCO must make a good-faith effort to provide affected members with written notice of a provider’s termination from the MCO’s network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.</p>	<p>This requirement is addressed in the policy and procedure for UHC community and state provider-initiated voluntary termination that states the notice to the member must be provided within 15 calendar days from the receipt of the termination notice from the provider. Actual letters were provided regarding voluntary termination of providers (as opposed to template letters). Two (2) of these letters were sent 60 days after receipt of the termination notice from the provider and one (1) was sent at almost 90 days.</p> <p><b>Recommendation:</b> UHCCP should examine the timeliness of the letters that are distributed to members, and ensure that members are notified within 15 days of when the MCO receives the termination notice from the provider.</p>	<p>UHCCP’s policy states that notice to the member of a provider termination should be provided within 15 calendar days from the receipt of the termination notice from the provider.</p> <p>UHCCP has identified the root cause of the late notice letters and found that both examples were related to a work routing issue.</p> <p>As a result of the findings, we have updated our work routing processes, and will continue with ongoing monitoring of the processes, which will be reported up through to the Compliance Oversight Committee.</p>

MCO: managed care organization; UHC: UnitedHealthcare. UHCCP: UnitedHealthcare Community Plan of Nebraska.

### Quality Management

The evaluation of quality management 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; PIPs; HEDIS final audit report (FAR); 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 58 standards/substandards were reviewed; 55 were fully compliant and three (3) were deemed not applicable.

### Utilization Management

The evaluation of utilization management 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 65 standards/substandards were reviewed; all were fully compliant.

### 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 39 standards/substandards were reviewed; 38 standards/substandards were fully compliant and one (1) was substantially compliant. Grievances and appeals substantially compliant standards/substandards are presented in **Table 19**.

Table 19: UHCCP Grievances and Appeals – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	UHCCP Response and Action Plan
<p>A member may file a grievance with the MCO or the state at any time.</p>	<p>This requirement is addressed within POL2015-04 Appeal and Grievance policy and procedure on page 8, which states, “A member may file a grievance at any time.” The member handbook states, on page 126, that the member can send a complaint at any time. This, however, is following the section regarding civil rights, and not outlined explicitly in the grievances section of the member handbook (on page 111). Further, pertaining to civil rights, letters were updated January 2018, since they initially stated complaint had to be filed within 60 days of when grievance was experienced (as opposed to at any time). This update was approved by the state in February; however, the templates were not put into production until April.</p> <p><b>Recommendation:</b> The MCO should consider incorporating language related to filing a grievance at any time on page 111. Further, the MCO should ensure that the new template outlining the member’s right to file a complaint regarding civil rights discrimination at any time is consistently being utilized.</p>	<p>UnitedHealthcare Community Plan has updated its member handbook to include language that a member may file a grievance at any time, which was approved by MLTC for use as of August 14, 2018. Further, the Health Plan has verified that the template outlining the member’s right to file a complaint regarding civil rights discrimination at any time has been implemented, and will continue to monitor that it is consistently being utilized.</p>

UHCCP: UnitedHealthcare Community Plan of Nebraska; MCO: managed care organization; MLTC: Medicaid and Long-Term Care.

### 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 59 standards/substandards were reviewed; 50 standards/substandards were fully compliant, eight (8) were substantially compliant, and one (1) was non-compliant. Care management substantially compliant standards/substandards are presented in **Table 20**, and non-compliant standards/substandards are presented in **Table 21**.

Table 20: WellCare Care Management – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
<p>CM must engage members in self-management strategies to monitor their disease processes and improve their health.</p>	<p>Sixteen (16) of 20 files reviewed included self-management strategies. One (1) file did not meet the requirement and one (1) file was not applicable.</p>	<p>Exploring self-management strategies is an expectation through the care planning process based on the member’s interest and willingness to engage. WellCare will evaluate the internal audit process of</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	<p><b>Recommendation:</b> Members should be engaged in self-management strategies for identified diseases/conditions, and these strategies should be documented in the case file.</p> <p>It is suggested that WellCare evaluate populations and then, within those populations, identify the individual member’s needs.</p>	<p>care managers to ensure opportunities to pursue disease state interventions and self-management are documented.</p>
<p>Risk stratification level assignment</p>	<p>Twelve (12) of 20 files reviewed included a risk stratification level. For the remaining eight (8) files, WellCare produced a separate listing of this information.</p> <p><b>Recommendation:</b> The assigned risk stratification level should be documented in each care management file. It is important to stratify clients into high, medium, and low risk. Sometimes a client can have multiple conditions but maintain a very satisfactory level of health. WellCare should describe how its risk stratification model accounts for this.</p>	<p>WellCare agrees that risk stratification is an important component of the CM process. WellCare will evaluate our internal documentation process to ensure that stratification levels are included in files.</p>
<p>The MCO must ensure that “active treatment” is being provided to each member.</p>	<p>Nineteen (19) of 20 files reviewed met this requirement. The plan of care in one (1) file was not implemented until 2 months after the health risk assessment was completed.</p> <p><b>Recommendation:</b> A plan of care should be implemented timely upon member enrollment in care management and completion of the health risk assessment.</p>	<p>The CM typically has 30 days from the date of referral to complete an assessment and document a care plan. WellCare will evaluate the internal audit process of care managers to ensure the timely development and implementation of care plans is appropriately documented.</p>
<p>Assistance with appointment scheduling and identifying participating providers, when necessary.</p>	<p>Twelve (12) of 20 files reviewed met this requirement. Seven (7) files were not applicable and one (1) file lacked evidence of assistance.</p> <p><b>Recommendation:</b> As needed, care management files should reflect assistance with appointment scheduling and identification of participating providers.</p>	<p>WellCare will evaluate the internal audit process of care managers to ensure efforts to assist with appointment scheduling and to identify participating providers are appropriately documented.</p>
<p>Assistance with CM and accessing primary care, behavioral health, and preventive and specialty care, as needed.</p>	<p>Twelve (12) of 20 files reviewed met this requirement. Seven (7) files were not applicable and one (1) file lacked evidence of assistance.</p> <p><b>Recommendation:</b> As needed, care management files should reflect</p>	<p>WellCare will evaluate the internal audit process of care managers to ensure efforts to assist with accessing primary care, behavioral health, and preventive and specialty care are appropriately documented.</p>

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	assistance with accessing primary care, behavioral health, and preventive and specialty care.	
Continuity of care that includes collaboration and communication with other providers involved in a member’s transition to another level of care.	<p>Eleven (11) of 20 files reviewed met this requirement. Seven (7) files were not applicable and two (2) files lacked evidence of continuity of care.</p> <p><b>Recommendation:</b> As needed, care management files should reflect continuity of care, including collaboration and communication with other providers involved in a member’s transition to another level of care. Appropriate personnel including the PCP should be kept informed of the member’s treatment needs, changes, progress, or problems.</p>	WellCare submitted CM files to cover the audit look-back period rather than full files, and this may have limited the opportunity to assess continuity of care. WellCare plans to evaluate the materials sent to PCPs when cases are closed to ensure continuity of care.
For members in medium-risk CM, MCO must facilitate relapse prevention plans with PCPs.	<p>Two (2) of 20 files reviewed met this requirement and 16 files were not applicable. Two (2) files did not demonstrate facilitation of relapse prevention.</p> <p><b>Recommendation:</b> Care management files should include relapse prevention plans for members with depression and other high-risk behavioral health conditions. WellCare should partner with behavioral health providers to develop a universal relapse condition plan for higher volume patient needs, such as depression.</p>	WellCare will review recovery and resiliency plans which address relapse prevention and implement the use of a plan to meet the individual health care of needs of our members.
Coordination with the Division of Children and Family Services.	<p>WellCare provided C7-BH-006, Nebraska – Behavioral Health Collaboration with Division of Children and Family Services and C7-BH-006-PR-001, Nebraska – Behavioral Health Collaboration with Division of Children and Family Services. A similar policy for non-behavioral health collaboration was not provided.</p> <p><b>Recommendation:</b> WellCare should establish a policy for non-behavioral health care coordination with the Division of Children and Family Services.</p>	WellCare will review and update the identified policy to ensure the appropriate requirements are included.

CM: care management; MCO: managed care organization; PCP: primary care provider.

Table 21: WellCare Care Management – Non-Compliant Standards/Substandards

Non-Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	<p>WellCare provided C7 UM-4.5, Care Coordination, Continuity of Care, and Transition of Care. This procedure addresses transition to another MCO, but does not address transition to another PCP.</p> <p><b>Recommendation:</b> WellCare should establish a policy/procedure that addresses maintenance of care plans and referral services when a member changes PCPs.</p>	WellCare will review and update the identified policy to ensure the appropriate requirements are included.

PCP: primary care provider; MCO: managed care organization.

### 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 65 standards/substandards were reviewed; 64 standards/substandards were fully compliant and one (1) was substantially compliant. Provider network substantially compliant standards/substandards are presented in **Table 22**.

Table 22: WellCare Provider Network – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Wait times for scheduled appointments should not routinely exceed 45 minutes	<p>The 45-minute wait time standard is stated in the MCO’s network development policy (WHP-PR6-C6ND MD-001 Network Development). However, the language in the provider manual in Access Standards and the member handbook Grievances section do not specifically indicate that wait times for scheduled appointments should not routinely exceed 45 minutes.</p> <p><b>Recommendation:</b> WellCare should update the member handbook and the provider manual with the language related to the 45-minute wait time.</p>	WellCare will update our member and provider handbooks so that the appropriate requirement is included.

MCO: managed care organization.

### Provider Services

The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.

A total of four (4) standards/substandards were reviewed; all four (4) were substantially compliant. Provider services substantially compliant standards/substandards are presented in **Table 23**.

Table 23: WellCare Provider Services – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
<p>The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.</p>	<p>Written complaints are considered formal complaints and are routed to the Grievance department. Complaints received by phone and not resolved are routed through the provider escalation team to the Grievance department. WellCare is in the process of amending its policies to address informal disputes (complaints received and resolved by phone). Informal disputes are maintained in the MCO’s customer service database.</p> <p><b>Recommendation:</b> WellCare’s policies/procedures should clearly define informal complaints (disputes) and formal provider complaints and include a description of how each is tracked and reported.</p>	<p>WellCare is currently revising the identified policy to clarify the difference between provider complaints and informal verbal inquiries/disputes. The updated policy will describe the different processes for each type of provider concern.</p>
<p>Provider complaint system must be capable of identifying and tracking complaints received by telephone, in writing, or in person on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.</p>	<p>The grievance system log provided only includes complaints filed by a provider on a member’s behalf and appeals. Provider complaints were not included. WellCare explained that provider complaints are captured in their grievance system, and a report is in development that will address provider complaints.</p> <p><b>Recommendation:</b> WellCare should document and implement a process for reporting provider complaints. Evidence of reporting should be provided during the next compliance review.</p>	<p>WellCare will implement a process for reporting provider complaints and provide evidence of this reporting for the next audit period.</p>
<p>The MCO must prepare and implement written policies and procedures that describe its provider complaint system.</p>	<p>Policy WHP-C6 GR-NE-30 inconsistently states the timeframe for providers to file a complaint, and does not address complaints that may be filed directly to MLTC. The provider handbook does not address a process by which providers are allowed to consolidate complaints. The provider’s opportunity to present in person was not found in policy, the provider handbook, or on the MCO website.</p> <p>Of the 10 files reviewed, six (6) were completed timely and nine (9) included a</p>	<p>WellCare’s updated provider was approved by MLTC 8/10/18. WellCare will review to ensure all elements are addressed and implemented. Updates to the provider handbook regarding consolidating complaints and the opportunity to present complaints in person are currently in progress.</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	<p>resolution notice.</p> <p><b>Recommendation:</b> An updated policy addressing all requirements should be implemented upon MLTC approval. The provider handbook should include instructions for providers for consolidating complaints regarding multiple claims that involve the same or similar payment or coverage issues.</p> <p>The provider’s opportunity to present in person should be documented in MCO policy and in the provider handbook.</p> <p>Provider complaints should be resolved within the MCO-defined timeframe. All files should include a copy of the resolution notice sent to the provider.</p>	
<p>The MCO must include a description of the provider complaint system in its provider handbook and on its provider website.</p>	<p>A screenshot of WellCare’s website was provided; the timeframes for filing a request and for resolution of the complaint are not consistent with the timeframes stated in the MCO’s policy. The MCO explained that an updated policy is awaiting MLTC approval. The 2018 Medicaid provider handbook was also provided. Similarly, the resolution timeframe stated is not consistent with the MCO policy.</p> <p><b>Recommendation:</b> An updated policy addressing all requirements should be implemented upon MLTC approval. WellCare should ensure that the MCO website and provider handbook are consistent with the updated policy.</p>	<p>WellCare’s updated provider complaint system policy was approved by MLTC 8/10/18. WellCare will review to ensure all elements are addressed and implemented. Updates to the provider handbook to ensure consistency are in progress.</p>

MCO: managed care organization; MLTC: Medicaid and Long-Term Care.

### 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; all were fully compliant.

### Member Services and Education

The evaluation of member services and education 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 61 standards/substandards were reviewed; 59 standards/substandards were fully compliant and two (2) were substantially compliant. Member services and education substantially compliant standards/substandards are presented in **Table 24**.

**Table 24: WellCare Member Services and Education – Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
<p>Oral Interpretation and Written Translation Services</p>	<p>There is no language within the policies and procedures reviewed which states the following: “The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately.”</p> <p>During the onsite interview, the MCO stated they provide translation services for all written marketing materials in any language that is spoken by 5% or more members.</p> <p><b>Recommendation:</b> The MCO should add the missing contract requirement to the policy, and follow the written standard of providing translation services for all written marketing member materials in any language spoken by 4% or more members.</p>	<p>WellCare will revise the relevant policy so that it clearly states the contract requirement and will adhere to this requirement.</p>
<p>The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment.</p>	<p>This requirement is partially addressed in WellCare’s corporate policy “Updates to the WellCare Websites Policy,” page 37, bullet d. There is a discrepancy for the number of days the MCO must distribute member materials: the policy says within 30 days, and the state contract says within 10 days.</p> <p><b>Recommendation:</b> The MCO should update the policy to reflect the 10-calendar-day standard.</p>	<p>This standard was changed from the original RFP standard of 30 days to 10 days in Addendum 6. While WellCare follows the 10-day standard, the policy was not updated. The identified policy will be revised to reflect the contract standard of 10 days to distribute member welcome packets.</p>

MCO: managed care organization; MLTC: Medicaid and Long-Term Care.

## Quality Management

The evaluation of quality management 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; PIPs; HEDIS final audit report (FAR; 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 58 standards/substandards were reviewed; 55 standards/substandards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. Quality management substantially compliant standards/substandards are presented in **Table 25**.

**Table 25: WellCare Quality Management – Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health, and substance use disorder treatment of children, adolescents, and adults in the state should be included as part of the QAPIC.	Representation was lacking from knowledgeable providers.  <b>Recommendation:</b> The MCO should have representation from providers knowledgeable about disability, mental health, and substance use disorder treatment of children, adolescents, and adults in the state.	WellCare will solicit member recommendations from providers currently serving on committees, as well as the general provider network in order to ensure representation from providers knowledgeable about disability, mental health, and substance use disorder.
The MCO must provide an orientation and ongoing training for Member Advisory Committee members.	The MCO noted the incorrect year (2016) is indicated on the PowerPoint training presentation.  <b>Recommendation:</b> The MCO should update the MAC PowerPoint training presentation to include the appropriate year, and further provide evidence of these trainings (such as attendance sheets).	WellCare offers this training whenever a new member joins the committee. The training was last completed in March 2018 and is planned again for September 2018. The committee minutes will reflect the training dates and provide evidence of training completion for the next audit period. The training deck has been updated and will be shared with IPRO at our next audit opportunity.

PCP: primary care provider; QAPIC: Quality Assurance and Performance Improvement Committee; MCO: managed care organization; MAC: Member Advisory Committee; IPRO: Island Peer Review Organization.

## Utilization Management

The evaluation of utilization management 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 65 standards/substandards were reviewed; 63 were fully compliant and two (2) were substantially compliant. Utilization management substantially compliant standards/substandards are presented in **Table 26**.

**Table 26: WellCare Utilization Management – Substantially Compliant Standards/Substandards**

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
Processes and procedures to address disparities in healthcare.	This requirement is not explicitly addressed in the UM Program Description. Some references are made to social and psychosocial needs and co-morbidities.	WellCare will update the UM Program Description to reflect the process for addressing disparities in health care. WellCare's UM staff identify members in need of care management support due

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	<p><b>Recommendation:</b> The MCO should incorporate the required language in the UM Program Description and create policies and procedures to address disparities in healthcare.</p>	<p>to disparaging conditions (complex discharges/catastrophic diagnoses, etc.) during the authorization review process. If identified, UM staff refers these members to the care management team for follow-up and collaborative management of member needs.</p>
Standard Service Authorization Denial.	<p>Nine (9) of 10 files met this requirement. The non-compliant file contained evidence that the request was received on 11/16/17 and the decision to deny was sent 17 days later on 12/3/17 (i.e., outside of the permitted 14-day window).</p> <p><b>Recommendation:</b> The MCO should implement a process to assess ability to comply with the timeliness standard.</p>	<p>WellCare’s UM team has implemented daily inventory meetings with UM leadership to assess current inventory and ensure timely processing of authorization requests. WellCare ensures determinations are made within required timeframes by closely monitoring various systems and reports throughout the day, including authorization inventory reports. These reports allow authorization staff and UM leadership to closely monitor and view the status of all authorization requests to ensure determinations are rendered and appropriate notices are given within required timeframes.</p>

UM: Utilization Management; MCO: managed care organization.

## 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 39 standards/substandards were reviewed; 38 standards/substandards were fully compliant and one (1) was substantially compliant. Grievances and appeals substantially compliant standards/substandards are presented in **Table 27**.

Table 27: WellCare Grievances and Appeals – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
The MCO must acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	<p>For the grievance files, in one (1) of 20 files the acknowledgement letter was dated more than 10 calendar days after receipt of the grievance.</p> <p>For the appeals files, in two (2) of 10 files, the acknowledgement letter was dated more than 10 calendar days after receipt of the appeal.</p> <p><b>Recommendation:</b> IPRO recommends that timely (within 10 calendar days of receipt) acknowledgement letters be provided to</p>	<p>Both the Appeals and Grievance departments have several mechanisms in place to ensure appeals and grievances are processed within the applicable state contracted timeframes. The departments have a dashboard that runs daily to capture the department’s daily inventory and lists all files that require acknowledgment and closure. The dashboard captures all expedited, pre-service, retrospective appeals and grievances, the date of receipt, status of grievance, reason for appeal and</p>

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	WellCare Response and Action Plan
	all members filing a grievance or appeal.	<p data-bbox="1003 176 1479 558">grievance, line of business, compliance timeframe, and other pertinent information needed to manage the day-to-day operations of the departments. The department’s senior director, managers, and supervisors use the dashboards to prioritize work and manage the inventory throughout the day to ensure cases are addressed and resolved according to established timeframes.</p> <p data-bbox="1003 569 1479 772">Team supervisors and team leads will discuss processing timeframe goals and metrics on an ongoing basis, assuring that all team members take accountability for processing files within the compliance timeframe.</p> <p data-bbox="1003 814 1479 982">Re-education will be given, as needed, for files that are nearing compliance timeframes. In addition, a quality auditing process reviews and monitors missed elements of compliance.</p>

MCO: managed care organization; IPRO: Island Peer Review Organization.

### Accreditation and NCQA Ratings

NE DHHS requires that, for their Medicaid lines of business, MCOs maintain NCQA accreditation and the DBPM maintain URAC (Utilization Review Accreditation Committee) accreditation. 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 MCO 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, the 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 an 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 dimensions using star ratings between one and four stars (1 – lowest, 4 – highest)<sup>1</sup>:

- **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 network with 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 28 and 29 depict the MCOs’ star ratings and accreditation status.

Table 28: NTC, UHCCP and WellCare NCQA Accreditation Ratings for Medicaid — 2017

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

<sup>1</sup> NCQA star ratings: 4 stars = highest; 1 star = lowest.

NTC: Nebraska Total Care; UHCCP: UnitedHealthcare Community Plan; N/A: Accreditation ratings were not available for NTC due to insufficient data.

Table 29: NTC, UHCCP and WellCare NCQA Accreditation Status for Medicaid — 2018

Domain	NTC	UHCCP	WellCare
Accreditation Status	Interim	Commendable	Accredited

NTC: Nebraska Total Care; UHCCP: UnitedHealthcare Community Plan.

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 2018, 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 due to insufficient data.

The rated categories are detailed below, with UHCCP’s rate information following in **Table 30**.

- **Consumer Satisfaction:** This category includes CAHPS measures about consumer experience with getting care, as well as satisfaction with MCO physicians and MCO services.

<sup>1</sup> <https://www.ncqa.org> .

- **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 30: UHCCP NCQA Medicaid Ratings by Category — 2018

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

The URAC accreditation program requires compliance with industry best practices in all areas of dental plan management, including member and provider services, utilization management, grievances and appeals, provider contracting, credentialing, human resources, quality improvement, and regulatory and HIPAA (Health Insurance Portability and Accountability)/HITECH (Health Information Technology for Economic and Clinical Health Act) compliance. Dental plans that achieve the URAC Accreditation Seal differentiate themselves by demonstrating a commitment to continuous quality improvement and by verifying their adherence to a set of rigorous quality standards.<sup>2</sup> URAC reviewed MCNA on 12/1/2017. The DBPM is fully accredited, with this designation expiring 12/1/2020.

### Validation of Performance Measures and Assignment of HEDIS Performance Measure Rates to Performance Domains

This section of the report summarizes NTC’s, UHCCP’s, and WellCare’s reporting of select performance measures, HEDIS audit results, and recommendations for developing interventions to improve care based on their 2018 HEDIS scores.

#### Nebraska Total Care

As an NCQA-accredited managed care organization, NTC annually reports HEDIS measures to the NCQA. As required by NCQA, the production and reporting processes used to calculate the HEDIS measures were audited by Attest Health Care Advisors, an NCQA-licensed organization. IPRO reviewed the FAR produced by Attest Health Care Advisors to determine whether NTC appropriately followed the HEDIS guidelines in calculating the measures and whether the measures were deemed to be reportable.

IPRO’s review of Attest Health Care Advisors’ FAR indicated that NTC’s measures were prepared according to the HEDIS technical specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.

To make an overall assessment about the quality, timeliness, and access to care provided by NTC and to track performance over the past year, IPRO assigned select HEDIS measures to one (1) or more of the three (3) domains depicted in **Table 31**.

In the domain of **quality**, NTC performed **better than** the national Medicaid HMO averages for Use of Imaging for Low Back Pain, Antidepressant Medication Management – Effective Acute Phase, and Antidepressant Medication Management – Effective Continuation Phase. The MCO reported rates **below** the national Medicaid HMO averages for Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Lead Screening in Children, Adolescent Immunizations – Combination 1, Childhood Immunizations – Combination 2, Childhood Immunizations – Combination 3, Childhood Immunizations – Combination 10, Comprehensive Diabetes Care Blood Pressure < 140/90, and Controlling High Blood Pressure.

Of note, the rates for Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Adolescent Immunizations –

<sup>2</sup> <https://www.urac.org>.

Combination 1, Childhood Immunizations – Combination 2, Childhood Immunizations – Combination 3, Childhood Immunizations – Combination 10, and Controlling High Blood Pressure were **at or below** the national Medicaid 10th percentile.

In the domain of **timeliness**, NTC performed **better than** the national Medicaid HMO averages for Monitoring for Persistent Medications, Comprehensive Diabetes Care – HbA1c Measurement. The MCO reported rates **below** the national Medicaid HMO averages for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Comprehensive Diabetes Care – Retinal Exam, Comprehensive Diabetes Care – Nephropathy Monitoring, Timeliness of Prenatal Care, Postpartum Exam, Well-Child Visits 3–6 Years, and Adolescent Well-Care Visits.

Of note, the rates for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Comprehensive Diabetes Care – Nephropathy Monitoring, Postpartum Exam, and Well-Child Visits 3–6 Years were **at or below** the national Medicaid 10th percentile.

In the domain of **access**, NTC performed **better than** the national Medicaid HMO averages for Children and Adolescents' Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years), Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years), and Ambulatory Care – ED Visits/1,000 MM.

Of note, the rate(s) for Children and Adolescents' Access to Primary Care Practitioners (12–24 Months) and Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years) were **at or above** the national Medicaid 90th percentile.

### **UnitedHealthcare Community Plan of Nebraska**

As an NCQA-accredited managed care organization, UHCCP annually reports HEDIS measures to the NCQA. As required by the NCQA, the production and reporting processes used to calculate the HEDIS measures were audited by Attest Health Care Advisors, an NCQA-licensed organization. IPRO reviewed the FAR produced by Attest Health Care Advisors to determine whether UHCCP appropriately followed the HEDIS guidelines in calculating the measures and whether the measures were deemed to be reportable.

IPRO's review of Attest Health Care Advisors' FAR indicated that UHCCP's measures were prepared according to the HEDIS technical specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.

To make an overall assessment about the quality, timeliness, and access to care provided by UHCCP and to track performance over the past year, IPRO assigned select HEDIS measures to one or more of the three domains depicted in **Table 31**.

In the domain of **quality**, UHCCP performed **better than** the national Medicaid HMO averages for Adult BMI Assessment, Human Papillomavirus Vaccine for Female Adolescents, Lead Screening in Children, Adolescent Immunizations – Combination 1, Childhood Immunizations – Combination 2, Childhood Immunizations – Combination 3, Childhood Immunizations – Combination 10, Comprehensive Diabetes Care Blood Pressure < 140/90, Controlling High Blood Pressure, Use of Imaging for Low Back Pain, Antidepressant Medication Management – Effective Acute Phase, and Antidepressant Medication Management – Effective Continuation Phase. The MCO reported rates below the national Medicaid HMO averages for Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, and Medication Management for People with Asthma – 75%.

Of note, the rates for Childhood Immunizations – Combination 2, Childhood Immunizations – Combination 3, Childhood Immunizations – Combination 10, Antidepressant Medication Management – Effective Acute Phase, and Antidepressant Medication Management – Effective Continuation Phase were **at** the national Medicaid 90th/95th percentile. The rate for Child/Adolescent BMI Assessment was **at** the national Medicaid 10th percentile.

In the domain of **timeliness**, UHCCP performed **better than** the national Medicaid HMO averages for COPD Spirometry Testing, Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Monitoring for Persistent Medications, Appropriate Treatment for URI, Breast Cancer Screening, Comprehensive Diabetes Care – Retinal Exam, Comprehensive Diabetes Care – HbA1c Measurement, Comprehensive Diabetes Care – Nephropathy Monitoring, Follow-up for ADHD Medication – Initiation Phase, Postpartum Exam, Well-Child Visits (0–15 Months, 6+ Visits), and Adolescent Well-Care Visits. The MCO reported rates **below** the national Medicaid HMO averages for Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Follow-up for ADHD Medication – Continuation and Maintenance Phase, Timeliness of Prenatal Care, and Well-Child Visits (3–6 Years).

Of note, the rates for Pharmacotherapy Management of COPD – Bronchodilator and Well-Child Visits (3–6 Years) were **at** the national Medicaid 90th/95th percentile. The rates for Appropriate Pharyngitis Testing and Chlamydia Screening were **at or below** the national Medicaid 10th percentile.

In the domain of **access**, UHCCP performed **better than** the national Medicaid HMO averages for Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years), Adults’ Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years), and Ambulatory Care – ED Visits/1,000 MM.

Of note, the rates for Children and Adolescents’ Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, and 12–19 Years) and Adults’ Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years) are **at** the national Medicaid 90th/95th percentile. The rate for Ambulatory Care – ED Visits/1,000 MM was **at** the national Medicaid 10th percentile.

### WellCare Health Plan of Nebraska

As an NCQA-accredited managed care organization, WellCare annually reports HEDIS measures to the NCQA. As required by NCQA, the production and reporting processes used to calculate the HEDIS measures were audited by HealthcareData Company, an NCQA-licensed organization. IPRO reviewed the FAR produced by HealthcareData Company to determine whether WellCare appropriately followed the HEDIS guidelines in calculating the measures and whether the measures were deemed to be reportable.

IPRO’s review of HealthcareData Company’s FAR indicated that WellCare’s measures were prepared according to the HEDIS technical specifications and present fairly, in all material respects, the organization’s performance with respect to these specifications.

To make an overall assessment about the quality, timeliness, and access to care provided by WellCare and to track performance over the past year, IPRO assigned select HEDIS measures to one (1) or more of the three (3) domains depicted in **Table 31**.

In the domain of **quality**, WellCare performed **better than** the national Medicaid HMO averages for Lead Screening in Children, Childhood Immunizations – Combination 10, Comprehensive Diabetes Care Blood Pressure < 140/90, Controlling High Blood Pressure, Use of Imaging for Low Back Pain, Antidepressant Medication Management – Effective Acute Phase, and Antidepressant Medication Management – Effective Continuation Phase. The MCO reported rates **below** the national Medicaid HMO averages for the measures Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Adolescent Immunizations – Combination 1, Childhood Immunizations – Combination 2, and Childhood Immunizations – Combination 3.

Of note, the rates for Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Human Papillomavirus Vaccine for Female Adolescents, Childhood Immunizations – Combination 2, and Childhood Immunizations – Combination 3 were **at or below** the national Medicaid 10th percentile.

In the domain of **timeliness**, WellCare performed **better than** the national Medicaid HMO averages for Monitoring for Persistent Medications, Comprehensive Diabetes Care – HbA1c Measurement, Comprehensive Diabetes Care – Nephropathy Monitoring, and Adolescent Well-Care Visits. The MCO reported rates **below** the national Medicaid HMO averages for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Cervical Cancer Screening, Chlamydia Screening, Comprehensive Diabetes Care – Retinal Exam, Timeliness of Prenatal Care, Postpartum Exam, and Well-Child Visits (3–6 Years).

Of note, the rates for Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, and Postpartum Exam were **at or below** the national Medicaid 10th percentile.

In the domain of **access**, WellCare performed **better than** the national Medicaid HMO averages for all measures; Children and Adolescents' Access to Primary Care Practitioners (12–24 Months), Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years), Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years), and Ambulatory Care – ED Visits/1,000 MM.

Of note, the rate for Ambulatory Care – ED Visits/1,000 MM was **at** the national Medicaid 10th percentile (for this measure, a lower rate is desirable).

### Overall HEDIS Performance

In the domain of **quality**, the Nebraska Medicaid weighted averages were **above** the national Medicaid HMO averages for Lead Screening in Children, Adolescent Immunization – Combo 1, Childhood Immunization Combo – 10, Use of Imaging for Low Back Pain, and Antidepressant Medication Management – Effective Acute Phase and Effective Continuation Phase. The Nebraska weighted averages were **below** the national Medicaid HMO averages for Childhood Immunization Combo – 2, Childhood Immunization Combo – 3, Diabetes Care – BP < 140/90, Controlling for High Blood Pressure, Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Physical Activity, Child/Adolescent Counseling for Nutrition, and HPV Vaccine for Female Adolescents.

Of note, the rates for Child/Adolescent BMI Assessment, Counseling for Physical Activity, and Counseling for Nutrition were **at** the National Medicaid HMO 10th percentile.

In the domain of **timeliness**, Nebraska weighted averages were **above** the national Medicaid HMO average for Monitoring for Persistent Medications, Diabetes Care – HbA1c Measurement, and Adolescent Well Care Visits. The Nebraska weighted averages were **below** the national Medicaid HMO average for Cervical Cancer Screening, Chlamydia Screening, Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Diabetes Care – Retinal Exam, Diabetes Care – Nephropathy Monitoring, Timeliness of Prenatal Care, Postpartum Exam, Appropriate Treatment for URI, Appropriate Pharyngitis Testing, and Well-Child Visits 3–6 Years.

Of note, the rates for Cervical Cancer Screening, Chlamydia Screening, Pharmacotherapy Management of COPD – Systemic Corticosteroid, Pharmacotherapy Management of COPD – Bronchodilator, Timeliness of Prenatal Care, and Appropriate Pharyngitis Testing were **at or below** the national Medicaid HMO 10th percentile.

In the domain of **access**, Nebraska performed **above** the national Medicaid HMO average on all measures (Access to PCP 12–24 months, Access to PCP 25 months–6 years, Access to PCP 7–11 years, Access to PCP 12–19 years, Access to PCP 20–44 years, Access to PCP 45–64 years, and Access to PCP 65+ years), with the exception of Ambulatory Care – ED Visits, which was **below** the National Medicaid HMO average (for this measure, a lower rate is desirable). Of note, the rates for Access to PCP 12–24 Years, 20–44 Years, 45–65 Years, and 65+ Years were **at or above** the national Medicaid HMO 90th percentile.

Table 31: NTC, UHCCP and WellCare HEDIS 2018 Performance Measure Rates and Assignment to Performance Domains

HEDIS Measure	NTC	UHCCP	WellCare	Quality	Timeliness	Access	NE MMC Weighted Average	2018 Quality Compass Percentile Benchmark Met <sup>1</sup>	2018 National Medicaid HMO Average
<b>Effectiveness of Care</b>									
Adult BMI Assessment	N/A	92.45%	N/A	X	X		N/A	N/A	N/A
Child/Adolescent BMI Assessment	52.07%	60.34%	66.91%	X	X		59.72%	10th	Below
Child/Adolescent Counseling for Nutrition	45.01%	62.29%	58.39%	X	X		55.35%	10th	Below
Child/Adolescent Counseling for Physical Activity	43.31%	54.01%	48.91%	X	X		48.86%	10th	Below
Human Papillomavirus Vaccine for Female Adolescents	10.96%	39.90%	23.93%	X	X		32.63%	33.33rd	Below
Medication Management for People with Asthma (Total) – 50%	N/A	62.96%	N/A	X			N/A	N/A	N/A
Medication Management for People with Asthma (Total) – 75%	N/A	34.57%	N/A	X			N/A	N/A	N/A
COPD Spirometry Testing	N/A	38.98%	N/A		X	X	N/A	N/A	N/A
Pharmacotherapy Management of COPD – Systemic Corticosteroid	39.79%	79.90%	24.51%		X	X	42.28%	< 5th	Below
Pharmacotherapy Management of COPD – Bronchodilator	47.40%	91.24%	32.68%		X	X	50.60%	< 5th	Below
Monitoring for Persistent Medications	90.52%	91.97%	89.62%		X		90.79%	75th	Above
Appropriate Treatment for URI	83.09%	93.08%	83.23%		X		88.58%	33.33rd	Below
Appropriate Pharyngitis Testing	66.70%	70.59%	68.24%		X		68.59%	10th	Below
Lead Screening in Children	68.50%	80.05%	73.72%	X	X		76.92%	50th	Above
Breast Cancer Screening	N/A	59.00%	N/A		X	X	N/A	N/A	N/A
Cervical Cancer Screening	39.17%	58.76%	48.66%		X	X	46.77%	10th	Below
Chlamydia Screening (Total)	35.00%	32.92%	39.26%		X	X	35.65%	< 5th	Below
Adolescent Immunization-Combo 1	72.37%	84.43%	73.93%	X	X		80.77%	50th	Above
Childhood Immunizations-Combo 2	37.97%	83.45%	58.97%	X	X		71.20%	25th	Below
Childhood Immunizations-Combo 3	35.94%	81.27%	57.88%	X	X		69.21%	33.33rd	Below
Childhood Immunizations-Combo 10	20.00%	56.20%	35.53%	X	X		46.27%	75th	Above
Diabetes Care BP< 140/90	56.93%	67.68%	66.00%	X			60.78%	33.33rd	Below
Diabetes Care – Retinal Exam	53.77%	63.43%	56.24%		X	X	56.14%	33.33rd	Below
Diabetes Care – HbA1c Measurement	88.32%	90.29%	92.00%		X	X	89.41%	66.67th	Above
Diabetes Care – Nephropathy Monitoring	87.59%	90.44%	90.24%		X	X	88.66%	25th	Below

HEDIS Measure	NTC	UHCCP	WellCare	Quality	Timeliness	Access	NE MMC Weighted Average	2018 Quality Compass Percentile Benchmark Met <sup>1</sup>	2018 National Medicaid HMO Average
Controlling High Blood Pressure	44.28%	60.83%	57.18%	X			50.15%	25th	Below
Use of Imaging for Low Back Pain	75.44%	73.30%	74.92%	X			74.53%	50th	Above
Antidepressant Medication Management – Effective Acute Phase	58.19%	70.69%	54.22%	X	X	X	64.90%	90th	Above
Antidepressant Medication Management – Effective Continuation Phase	47.04%	60.82%	42.17%	X	X	X	54.36%	90th	Above
Follow-up for ADHD Medication – Initiation	N/A	44.85%	N/A		X		N/A	N/A	N/A
Follow-up for ADHD Medication - Continuation	N/A	50.15%	N/A		X		N/A	N/A	N/A
<b>Access/Availability of Care</b>									
Timeliness of Prenatal Care	76.89%	77.55%	76.40%		X	X	76.87%	10th	Below
Postpartum Exam	57.66%	68.62%	58.39%		X	X	61.02%	25th	Below
Access to PCP – 12-24 Months	98.18%	98.80%	96.29%			X	97.75%	> 90th	Above
Access to PCP – 25 Months–6 Years	90.78%	93.39%	89.25%			X	91.14%	75th	Above
Access to PCP – 7–11 Years	N/A	95.45%	86.67%			X	N/A	N/A	N/A
Access to PCP – 12–19 Years	N/A	95.66%	80.00%			X	N/A	N/A	N/A
Access to PCP – 20–44 Years	89.94%	91.24%	85.18%			X	88.87%	> 95th	Above
Access to PCP – 45–64 Years	95.83%	95.68%	88.93%			X	94.24%	> 95th	Above
Access to PCP – 65+ Years	96.59%	95.11%	90.89%			X	94.70%	90th	Above
<b>Utilization of Care</b>									
Ambulatory Care – ED Visits/1,000 MM (Total) <sup>2</sup>	63.07	48.04	48.10			X	53.55	33.33rd	Below
Antibiotic Utilization (Total) – Scripts PMPY	1.00	1.25	0.81		X	X	1.01	NBR	NBR
Well-Child Visits 0–15 Months 6+ Visits	N/A	79.17%	N/A		X	X	N/A	N/A	N/A
Well-Child Visits 3–6 Years	62.45%	72.52%	72.51%		X	X	69.28%	33.33rd	Below
Adolescent Well-Care Visits	47.90%	66.32%	57.18%		X	X	56.98%	50th	Above

<sup>1</sup> As reported in Quality Compass.

<sup>2</sup> For this measure, a lower rate is desirable.

NTC: Nebraska Total Care; UHCCP: UnitedHealthcare Community Plan; MMC: Medicaid managed care; HMO: health maintenance organization; BMI: body mass index; N/A: not applicable, as denominators for these measure rates are less than or equal to 30; NBR: benchmarks not reported publicly by NCQA for HEDIS 2018; COPD: chronic obstructive pulmonary disease; URI: upper respiratory infection; BP: blood pressure; ADHD: attention-deficit/hyperactivity disorder; PCP: primary care provider; ED: emergency department; MM: member months; PMPY: per member per year.

## Validation of Performance Improvement Projects

Medicaid MCEs 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 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. MCO PIP proposals were submitted on December 1, 2017 ahead of PIP implementation on January 1, 2018. Update reports were received throughout the year. MCNA's PIP proposals were received October 31, 2018 ahead of PIP implementation on January 1, 2019. Each of these PIPs is discussed separately, below.

### MCNA

#### PIP: Annual Dental Visit (ADV)

MCNA proposed a PIP to increase the percentage of members receiving annual dental visits. The PIP employs the modified HEDIS ADV measure, stratified into three age groups: 2–20 years, 1–20 years, and 21+ years. The ADV measure evaluates the percentage of members in the eligible population who saw a dentist during the reporting year. The baseline period for the PIP was 1/1/18–12/31/18. Analysis of MCNA's baseline data showed the ADV rate for ages 2–20 was 68.2%, the rate for ages 1–20 was 64.9%, and the rate for ages 21+ was 42.6%. The final goal for ages 2–20, 1–20, and 21+ were 69.7%, 67.9%, and 44.1%, respectively.

Member-specific barriers cited by MCNA include members not receiving routine dental visits and instead waiting until they feel pain, lack of oral health knowledge, and language and cultural barriers. A provider-specific barrier identified by MCNA was that PCPs are unaware of MCNA's participating provider network within the proximity of their offices. Member-specific interventions designed to overcome those barriers were text messages to members who have not seen a dentist in the last 6 months, care gap alerts to notify member service representatives that a member is overdue for a dental visit, a member newsletter to provide members with the latest news and developments regarding their oral health, Baby's First Toothbrush and DentalLink programs in partnership with PCPs, and member advocate outreach specialist participation in community outreach events/health fairs.

#### PIP: Preventive Dental Visit (Pdent)

MCNA proposed a PIP to increase the percentage of members receiving preventive dental visits for members aged 1–20 and members aged 21 and older. The PIP employs two performance indicators: percentage of members who received at least one (1) preventive dental service during the measurement year (two age strata: 1–20 years and 21+ years), and percentage of members who received at least two (2) preventive dental services 6 months apart during the measurement year (age strata: 1–20 years and 21+ years). The baseline period for the PIP was 1/1/18–12/31/18. The baseline rates for the percentage of members who received at least one (1) preventive dental service for the members aged 1–20 and 21+ were 54.6% and 21.0%, respectively. MCNA aims to increase this rate to 58.6% for the 1–20 years age group and to 23.0% for the 21+ age group. The baseline rates for the percentage of members who received at least two (2) preventive dental services for members aged 1–20 and 21+ were 27.1% and 8.4%, respectively. MCNA aims to increase this rate to 30.1% for the 1–20 years age group and to 10.4% for the 21+ age group.

Member-specific barriers cited by MCNA include members not receiving routine dental visits and instead waiting until they feel pain, lack of oral health knowledge, and language and cultural barriers. A provider-specific barrier that was identified by MCNA was that primary care dentists (PCDs) are not taking advantage of minimally applying fluoride when members are seeking treatment services only. A plan-specific barrier that MCNA faces is the lack of medical, diagnostic data that indicate the member, as a function of medical chronicity, is at higher risk for oral health disease; MCNA has no access to medical, diagnostic data for its members. Member-specific interventions cited by MCNA include text messages to members who have not seen a dentist in the last 6 months and for members in need of a recall visit, care gap alerts to notify member service representatives that a member is overdue for a dental visit, Baby's First Toothbrush program, and a member newsletter to provide members with the latest news and developments regarding their oral health. A provider-specific intervention cited by MCNA was to increase the fee for fluoride by \$5 to encourage increased utilization. To overcome the plan-specific barrier, MCNA will provide training on its DentalLink program for high-volume, medical, participating primary care provider (PCP) practices on how the PCPs should leverage the DentalLink referral, in

view of this high-risk population, to bridge coordination of medical and oral healthcare and the positive properties this synergy will have on the member’s overall health.

### Nebraska Total Care

#### PIP: Follow-up After Emergency Department (ED) Visit for Mental Health Illness (MHI) or Substance Use Disorder (SUD)

When members with mental illness or substance abuse present to the ED, 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 MHI or 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). Baseline data were collected for calendar year (CY) 2017 and demonstrate an opportunity for improvement across both measures, particularly for FUA (note that FUA rates should, however, be interpreted with caution due to small denominators); see **Table 32**.

Table 32: NTC PIP for Follow-up After Emergency Department Visit with a Diagnosis of MHI or SUD

Indicator	Rate	Numerator/ Denominator
Indicator 1a (FUM, 7-day follow-up)	46.3%	409/884
Indicator 1b (FUM, 30-day follow-up)	68.3%	605/884
Indicator 2a (FUA, 7-day follow-up, 13–17 years of age)	5.9%	2/34
Indicator 2b (FUA, 7-day follow-up, 18+ years of age)	5.8%	19/330
Indicator 2c (FUA, 30-day follow-up, 13–17 years of age)	11.8%	4/34
Indicator 2d (FUA, 30-day follow-up, 18+ years of age)	7.6%	25/330

FUM: Follow-up After ED Visit for Mental Illness; FUA: Follow-up After ED Visit for Alcohol and Other Substance Use; ED: emergency department.

Preliminary rates associated with each of the indicators have been reviewed for CY 2018. The following indicators demonstrate a decline in performance: percentage of members with 7-day follow-up after ED visit for MHI, and percentage of members with a 30-day follow-up after ED visit for MHI. In contrast, the following indicators showed improvement: percentage of members (13–17, and 18 years of age and older) who had a 7-day follow-up after ED visit for SUD, and the percentage of members (13-17, and 18 years of age and older) who had a 30-day follow-up after ED visit for SUD.

Member-specific barriers to follow-up care after ED visits cited by NTC 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). In order to overcome these barriers, NTC has implemented a more robust member outreach campaign, wherein they are offering behavioral health case management support and education, and addressing social determinants of health by offering free cellphones and transportation assistance. Throughout the course of 2018, NTC has demonstrated success in improving the percentage of members contacted by care management staff within 7 days of their ED visit (from 41% in Q1 and 62% in Q2 to 100% in Q3 and Q4). There remains an opportunity to continue identifying those with social determinants, given the very low number of members who the plan is targeting with value-added services based on identified need.

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. To-date, 100% of NTC’s 4,736 provider practices have received information on HEDIS measures and practice guidelines. These practices include PCPs, in an effort by NTC to fill the BH specialty gap in Nebraska by educating and engaging these providers.

Plan-specific barriers include difficulty identifying members who have had an ED visit in a timely manner. The intervention designed to target this issue has been placed on hold until April 2019, given the ability to receive admission,

discharge, transfer (ADT) reports is contingent on a connection the Nebraska health information exchange (NEHII) will make available during this time.

#### PIP: Initiation of 17-Hydroxyprogesterone (17P) in Pregnant Women

NTC 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.

Baseline data were collected for CY 2017 and demonstrate that less than a quarter (23.6%) of NTC members with a previous spontaneous preterm birth initiated 17P. In order to improve birth outcomes, NTC has identified several barriers and developed corresponding interventions.

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. NTC has instituted an educational outreach initiative aimed at providers with delivery privileges; however, while successful, there appears to be an opportunity for better identification of those providers.

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). NTC initiated a provider incentive program at the end of Q2 2018 that demonstrated improvement in securing NOP forms between Q3 and Q4 2018 (from 44.2% to 51.7%, respectively).

Member barriers include lack of knowledge on the prevention of preterm birth. The MCO has focused their efforts on initiation of care management for pregnant members who are eligible for 17P, and the MCO has demonstrated increased success throughout each quarter of 2018 in improving the percentage of eligible members who are outreached for care management services (from 25.8% in Q1 to 90.0% in Q4).

Data analysis from CY 2018 demonstrates an approximate 10 percentage point increase in the percentage of eligible women who have received 17P, with considerable progress being made in Q3 and Q4 2018. Further, the MCO explored the characteristics of members not receiving 17P and found that some members had various co-morbidities, some were unable to be reached (transient/homeless/lack of contact information on file), and others had been retro-enrolled, seen by a perinatologist, or were delayed in seeking timely prenatal care.

#### PIP: Tdap Vaccination in Pregnant Women

Pertussis, known commonly as whooping cough, is a respiratory disease caused by the bacterium *Bordetella 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: percentage of pregnant women with a Tdap vaccination at any point during pregnancy, and the percentage of women with a Tdap vaccination during the optimal time period during pregnancy (26–37 weeks gestation). Baseline data were collected for CY 2017 and reveal that 53.0% of NTC members received Tdap immunization at any point during pregnancy, while 45.5% received Tdap immunization during the optimal 27–36-week gestational age period.

Provider-specific barriers include lack of knowledge related to practice guidelines related to Tdap in pregnancy and benefits to newborns, lack of awareness on appropriate billing/reimbursement and coding for Tdap, and lack of a defined and sustainable vaccination process in offices related to those receiving vaccine through Vaccines for Children (VFC) versus Medicaid vaccination coverage. NTC instituted a provider education program in order to outreach providers each quarter. Mode of distribution of education included face-to-face outreach, town hall sessions, committee meetings (including joint operating committee and tribal committee), mailing, email, and provider relations contacts.

Member-specific barriers include lack of knowledge on benefits of Tdap vaccination during the last trimester of pregnancy.

The MCO has developed a mobile app intervention that includes targeted messaging to members. This intervention began in August 2018 and has not shown efficacy, as there was a very low number of members who registered in Q3 and Q4. Initiation of care management services, however, has shown promise, as the plan improved the percentage of members enrolled from 31% in Q1 to 79% in Q4.

Data analysis from CY 2018 reveals an improvement in Tdap vaccination, both overall and during the optimal gestational age period. NTC has improved by approximately 10 percentage points for each indicator.

### UnitedHealthcare Community Plan of Nebraska

#### 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). Baseline data were collected for CY 2017 and demonstrate an opportunity for improvement across both measures, particularly for FUA (note that FUA rates should, however, be interpreted with caution due to small denominators); see **Table 33**.

**Table 33: UHCCP PIP for Follow-up After Emergency Room Visit with a Diagnosis of MHI or SUD**

Indicator	Rate	Numerator/ Denominator
Indicator 1a (FUM, 7-day follow-up)	63.7%	690/1084
Indicator 1b (FUM, 30-day follow-up)	77.6%	841/1084
Indicator 2a (FUA, 7-day follow-up, 13–17 years of age)	38.1%	8/21
Indicator 2b (FUA, 7-day follow-up, 18+ years of age)	23.3%	40/172
Indicator 2c (FUA, 30-day follow-up, 13–17 years of age)	38.1%	8/21
Indicator 2d (FUA, 30-day follow-up, 18+ years of age)	27.9%	48/172

FUM: Follow-up After ED Visit for Mental Illness; FUA; Follow-up After an ED Visit for Alcohol and Other Substance Use; ED: emergency department.

The PIP goals are to increase the FUM 7- and 30-day rates to 79.8%, and increase the FUA 7- and 30-day rates to 30.4% and 33.2%, respectively. Preliminary rates associated with each of the indicators have been reviewed for CY 2018. All performance indicators showed a decline in performance from baseline for CY 2018.

Member-specific barriers cited by UHCCP include member non-compliance with follow-up visits, social determinants of health, and non-adherence to prescribed medication. UHCCP has employed 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.

The MCO also employed an intervention which addresses verification of medication refill through analysis of member pharmacy refills. Analysis of intervention tracking measure data by the MCO suggested that there was no correlation between ED visits and follow-up with medication refills. The MCO has decided to discontinue this intervention moving forward and allocate resources into additional interventions that will be carried out during CY 2019.

#### PIP: Initiation of 17-Hydroxyprogesterone (17P) in Pregnant Women

UHCCP is targeting pregnant women with a history of spontaneous preterm birth with its PIP titled “17-Hydroxyprogesterone (17P) 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 Chart Book, there are racial and

ethnic disparities in the early initiation of prenatal care. The performance indicator for the project is the proportion of UHCCP members in the eligible population who were continuously enrolled throughout the measurement year and had initiated 17P between the 16th and 26th week of gestation. Baseline data from CY 2017 demonstrated that just over a quarter (25.6%) of UHCCP's eligible population had 17P initiated between the 16th and 26th week of gestation. The goal for the PIP is to increase this rate to 35%.

Member-related barriers to 17P adherence that were 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 carried out 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 the provider advocate team to assist with clarifying 17P billing. During CY 2018, the MCO had success in utilizing the ONAF to help identify high-risk pregnancies among its membership.

Preliminary data analysis of the performance indicator for CY 2018 demonstrates improvement in the percentage of at-risk pregnant members who received 17P to 27.3%. The MCO acknowledges that in order to meet its goal for the PIP, additional interventions such as a provider incentive are warranted moving forward.

#### 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. The performance indicators to measure the success of the project are (1) the percentage of pregnant women who received Tdap immunization at any point during pregnancy, and (2) the percentage of pregnant women who received Tdap immunization during the optimal 27–36-week gestational age period. Baseline data from CY 2017 indicate that 63.1% of UHCCP pregnant members received the Tdap vaccination during pregnancy and 56.1% received the vaccination 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 cited by the MCO include resistance to immunization due to personal, cultural, or geographical reasons and non-compliance with prenatal visits. To address these barriers, the MCO has employed an intervention to leverage its Baby Blocks program to educate pregnant members on Tdap and promote compliance for vaccination during pregnancy. Additionally, the MCO has been carrying out case management outreach to pregnant members to educate them on the importance of keeping prenatal appointments. Provider-related barriers include lack of knowledge regarding the benefit of Tdap immunization during pregnancy and the lack of vaccine or staffing in the rural areas of Nebraska. To address these barriers, the MCO has employed an intervention whereby the maternal-child health coordinator and clinical practice consultants conduct outreach to obstetrician (OB) offices to assess gaps and opportunities to address education for providers on Tdap immunization during pregnancy.

Analysis of preliminary data for CY 2018 demonstrated a slight decrease from baseline in the percentage of members who received the Tdap vaccine during pregnancy. Similarly, there was a decrease from baseline for the percentage of members who received the Tdap vaccine during the optimal 27–36-week gestational age period. The MCO has demonstrated a need to implement additional interventions and target additional pregnant members to improve the rates for Tdap immunization during pregnancy.

#### WellCare Health Plan of Nebraska

##### PIP: Follow-up After Emergency Department (ED) Visit with a Diagnosis of Mental Health Illness (MHI) or Substance Use Disorder (SUD)

WellCare has proposed to close the gap between ED visits and follow-up care for mental health illness and substance use disorder. Specifically, the MCO seeks 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. Baseline data were collected for calendar year (CY) 2017 and demonstrate an opportunity for improvement across both measures, particularly for FUA (note that FUA rates should, however, be interpreted with caution due to small denominators); see **Table 34**.

**Table 34: WellCare PIP for Follow-up After Emergency Department Visit with a Diagnosis of MHI or SUD**

Indicator	Rate	Numerator/ Denominator
Indicator 1a (FUM, 7-day follow-up)	41.1%	184/448
Indicator 1b (FUM, 30-day follow-up)	63.2%	283/448
Indicator 2a (FUA, 7-day follow-up, 13–17 years of age)	6.9%	2/29
Indicator 2b (FUA, 7-day follow-up, 18+ years of age)	5.6%	9/161
Indicator 2c (FUA, 30-day follow-up, 13–17 years of age)	17.2%	5/29
Indicator 2d (FUA, 30-day follow-up, 18+ years of age)	10.6%	17/161

FUM: Follow-up After ED Visit for Mental Illness; FUA: Follow-up After ED Visit for Alcohol and Other Substance Use; ED: emergency department.

Preliminary rates associated with each of the indicators have been reviewed for CY 2018. The following indicators demonstrate a decline in performance: percentage of members 13–17 years of age with a 7-day follow-up after ED visit for SUD, percentage of members 13–17 years of age with a 30-day follow-up after ED visit for SUD, percentage of members with 7-day follow-up after ED visit for MHI, and percentage of members with a 30-day follow-up after ED visit for MHI. In contrast, the following indicators showed improvement: percentage of members 18 years of age or older who had a 7-day follow-up after ED visit for SUD and the percentage of members 18 years of age and older who had a 30-day follow-up after ED visit for SUD.

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 the MCO’s Community Assistance Line (CAL) and member newsletter articles which increase awareness of ED follow-up guidelines. Since inception of the project in 2018, the MCO has noted under-utilization of the CAL, with the understanding that it may be due, in part, to similar resources that are available through Boystown National Hotline and the Nebraska Family Hotline. The MCO continues to evaluate this intervention for effectiveness.

Provider-specific barriers were initially identified as provider awareness of ED-utilizing members and WellCare resources and provider awareness of ED follow-up guidelines. Since inception of the project, the MCO has found that provider understanding of the importance of timely follow-up or access was not a barrier experienced by our members. No trends and persistent barriers have been identified for provider education.

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. WellCare has demonstrated that they are making progress on utilizing the Nebraska health information exchange (NEHII) for identification and ongoing monitoring of members.

PIP: Initiation of 17-Hydroxyprogesterone in Pregnant Women with a History of Spontaneous Preterm Birth

WellCare hopes to mitigate the incidence of spontaneous preterm births in pregnant women through increased use of 17-Hydroxyprogesterone (17P) during pregnancy. The performance indicator for the project is the proportion of WellCare members in the eligible population who were continuously enrolled throughout the measurement year and had initiated 17P between the 16th and 26th week of gestation. Baseline data were collected for CY 2017 and demonstrated that less than a third (29.7%) of women with a previous spontaneous preterm birth initiated 17P. In order to improve birth outcomes, WellCare has identified several barriers and developed corresponding interventions, as follows:

WellCare identified member adherence to 17P injections as a barrier. 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. This intervention was not initiated in 2018, as internal approvals are still pending.

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, obstetrical needs assessment form (ONAF), WellCare's process for timely authorizing and dispensing of 17P, proper billing for pharmacy coverage, coding for a history of preterm birth, and presumptive eligibility. These interventions related to provider outreach commenced Q3 2018, wherein the MCO succeeded in outreaching all 162 providers targeted.

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 preterm birth query, Alere High-Risk OB Care Management, ONAF, and outreaching all prenatal providers of potentially eligible 17P members who were identified by the history of preterm birth query. The MCO was able to track the progress of these interventions and, as of Q4, has identified 20.8% of eligible members by medical claims, 64.0% by pharmacy claims, 27.0% by history of preterm birth query, and 22.0% by ONAF.

Preliminary data analysis for CY 2018 demonstrates a decline in the percentage of pregnant members with a history of preterm birth who received 17P. The MCO suspects this may have to do with a shortage of Makena in Q3 and Q4 2018. As a result, the MCO has expressed its intention of outreaching specialty pharmacies in 2019 to assess their access to 17P.

#### 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 and 36 weeks gestation. The performance indicators to measure the success of the project are (1) the percentage of pregnant women who received Tdap immunization at any point during pregnancy, and (2) the percentage of pregnant women who received Tdap immunization during the optimal 27–36-week gestational age period. Baseline data were collected for CY 2017, and revealed that 64.3% of members received Tdap immunization at any point during pregnancy, while 56.9% received Tdap immunization during the optimal 27–36-week gestational age period. Preliminary data analysis for CY 2018 demonstrates a slight increase in each indicator (0.8 percentage point increase in indicator 1, and a 1.1 percentage point increase in indicator 2). Although marginal, these improvements are notable, given the increase in denominator from 2017 to 2018 (2,481 pregnant members to 3,257).

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 statewide. Analysis of CY 2018 intervention tracking measures demonstrates that all 162 providers received educational materials for their members from their Quality Practice Advisors (QPAs). 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 QPAs will educate providers concerning Tdap administration during pregnancy, prevention of pertussis, and HEDIS immunization and prenatal and postpartum care (PPC) measures. As of Q4 2018, all 162 providers received this education.

MCO-level barriers include claim and encounter data completeness substantiating Tdap administration. WellCare QPAs will educate providers on NCQA HEDIS auditor-approved pseudoclaim database process and health information data site capabilities. As of Q4 2018, all 162 providers received this education. Further, the MCO has demonstrated notable improvement in capturing the percentage of members with a Tdap claim within the Nebraska State Immunization Information System (NESIIS). The MCO initially missed these members within their indicator calculations, given the majority of the members found through NESIIS had a primary payer other than WellCare at the time of their Tdap; therefore, WellCare would not have received the claim.

## 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 well as the addition of MCNA to cover dental benefits for Medicaid beneficiaries. As part of its Quality Strategy, the state requires that all MCEs have methods to determine the quality and appropriateness of care for all Medicaid enrollees under the Nebraska MMC 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, and 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](http://dhhs.ne.gov/medicaid/Documents/Quality%20Strategy%20for%20Heritage%20Health%20and%20the%20Medicaid%20Dental%20Benefit%20Program%202017.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 MCEs. 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.

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 these 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 **Nebraska Quality Strategy**).

## Nebraska Total Care

Throughout the course of 2018, NTC undertook several initiatives aimed at addressing healthcare disparities among its membership; this information was provided by the MCO:

In 2017, NTC evaluated the member population data and decided to focus efforts for 2018 on the subpopulation of the health plan’s costliest members: neonatal intensive care unit (NICU) babies. This evaluation on health disparities also supports the collaborative PIPs between the state and all three MCOs related to 17P during the recommended intervention time of 16–20 weeks gestation.

As described in the 2017 report, 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); see **Table 35**. Primary diagnoses for NTC NICU admissions are shown in **Table 36**.

Table 35: NTC 2018 NICU Admissions by Maternal Race and Ethnicity

Race/Ethnicity	Number of NICU Admissions	Percentage of NICU Admissions
White (non-Hispanic)	187	41%
Race/ethnicity not provided	117	25%
Hispanic	58	13%
Black (non-Hispanic)	50	11%
Mutually defined	26	6%
American Indian/Native Alaskan	12	3%
Asian Pacific Islander	6	1%
Total	456	100%

NTC: Nebraska Total Care; NICU: neonatal intensive care unit.

Table 36: NTC Primary Diagnosis of 2018 NICU Admissions

Row Labels	Admissions
PRETERM NEWBORN UNS WEEKS GESTATION	46
RDS OF NEWBORN	41
RESPIRATORY DISTRESS NEWBORN UNS	32
PT NB GESTATIONAL AGE 34 CMPL WK	24
EXTREMELY LOW BRTH WT NB UNS WEIGHT	20
OTH LOW BIRTH WT NB 2000-2499 GRAMS	14
PT NB GESTATIONAL AGE 35 CMPL WK	14
TRANSIENT TACHYPNEA OF NEWBORN	13
NEONATAL JAUNDICE UNSPECIFIED	12
OTHER NEONATAL HYPOGLYCEMIA	11
PT NB GESTATIONAL AGE 36 CMPL WK	11
PT NB GESTATIONAL AGE 33 CMPL WK	9
BACTERIAL SEPSIS NEWBORN UNS	9
PT NB GESTATIONAL AGE 32 CMPL WK	8
SINGLE LIVE INFANT DELIV VAGINALLY	7
OBS & EVAL NB SUSPCT INFEC COND R/O	6
FEEDING PROBLEM OF NEWBORN UNS	5
ACUTE RESPIRATORY DISTRESS	5
NEWBORN AFCTD MAT INF & PARASIT DZ	5
SINGLE LIVEBORN INFANT DELIV C-SECT	5
EXTREMELY LW BIRTH WT NB 500-749 G	5
HYPOGLYCEMIA UNSPECIFIED	5
1 LIVEBRN INFANT UNS AS PLACE BRTH	5
OTH LOW BIRTH WT NB 1750-1999 GRAMS	5
CONGENITAL MALFORMATION HEART UNS	4
OTHER APNEA OF NEWBORN	4
TWIN LIVEBORN INFANT DELIV C-SECT	4
OTH LOW BRTH WT NB 1250-1499 GRAMS	4

NTC: Nebraska Total Care; NICU: neonatal intensive care unit.

The 2018 data for NTC NICU population showed that the primary maternal race with NICU admissions was the white (non-Hispanic) population (41%), followed by the Hispanic population (13%), and the black (non-Hispanic) population at 11%. There was a significant number of NICU admissions with no race or ethnicity data defined. This information is consistent with the overall demographics of the NTC member population.

Primary diagnosis for NTC’s NICU population was related to prematurity and respiratory-related issues, along with low birth weight. The ZIP Code locations for NICU members were consistent with overall membership location. The locations of admissions showed that CHI (Alegent Bergan) had the highest number of admissions, followed by Nebraska Methodist, Bryan, and Nebraska Medicine.

Omaha metro regions had the highest number of admissions, with the north Omaha ZIP Code locations having a predominant number of admissions. The Grand Island and Kearney area had also a higher number than anticipated.

The black subpopulation data show that the primary areas of NICU admissions come from Omaha in locations to the north, mid-town, and south of the city. The hospital demographics were similar to the overall NICU admission data reflecting CHI-Bergan, Nebraska Medicine, and Bryan as the top admitting hospitals for this subpopulation. The primary

admitting diagnosis was consistent with the overall NICU admitting diagnosis data reflected in **Table 36**. For the black subpopulation, respiratory-related issues and prematurity, along with low birth weight, were the top related admitting diagnoses.

## Interventions

NTC has focused initiative efforts related to disparities on interventions identified through the 17P PIP. Though these initiatives affect all demographics, it is proven by research to have a high impact on increasing full-term deliveries and decreasing NICU admissions. NTC's initiatives for this project included payment incentives to providers for early notification of pregnancy and appropriate initiation and outcomes of 17P. Increasing NOP occurred through collaborative work by the state and all three MCOs by using a uniform NOP form for providers to submit. In addition, NTC implemented a provider incentive for submission of the plan-specific NOP form, which is linked to the health plan's data analytics and reporting for case management initiatives. This incentive has increased the overall early identification of pregnant members at NTC and has helped with early outreach and case management to at-risk pregnant members.

Distribution of newly redesigned Start Smart for Baby (SSFB) materials was implemented in 2018, with focused enhancements related to education pertaining to pregnancy, post-delivery, and NICU-related issues. The educational materials cover topics that help expecting and new moms gain awareness about how to stay healthy during pregnancy, risk factors, and caring for the newborn.

In August 2018, PACIFY, an interactive phone app that allows for 24/7 connection to a certified lactation consultant and a registered pediatric dietitian, was implemented. This app supports new moms with answers to questions related to breastfeeding and nutrition during that initial year of the newborn. Push messaging related to care and care gap-related issues is also utilized.

In Q3 and Q4 2018, a focused effort was made to review current case management activities for pregnant and NICU populations. A Centene Corporation program manager for the SSFB program visited NTC to review case management workflows, documentation, and data reports, and identify interventions to enhance the NTC Case Management program.

Additionally in 2018, the role of community health worker was developed and implemented to further enhance the case management team efforts related to pregnancy and other high-risk issues. This team is trained to assess the social determinant needs of the member and provide targeted education and interventions within the home and community setting. Interdisciplinary NICU rounding was established by case management and utilization management in 2018 to identify and review those high-risk cases that may require additional support or evaluation.

A targeted Foster Care Case Management program was also established with efforts of outreach and coordination with state and foster care entities to allow for better coordination and communication. Part of the program includes assessing pregnant foster care members and establishing early outreach.

In 2019, continued efforts will be pursued to increase early identification of pregnancy notices, increase appropriate 17P usage, and increase outreach and interventions to NTC's pregnant population overall. A collaborative effort is also being planned with the religious sector of North Omaha to brainstorm and develop action plans to further engage communities in education and promotion of healthy pregnancies.

## UnitedHealthcare 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 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.

The MCO is contracted with all tribal providers in the service area, as well as all federally qualified health centers. This information was provided by the MCO.

### 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.

- A review of the CAHPS results for 2018 for member satisfaction decreased slightly from the prior year results for “how often was it hard to find a personal doctor who speaks your language?” However, the satisfaction remained the same for “how often was it hard to find a personal doctor who understands your culture?” There are no issues or trends identified.
- Member and provider appeals are tracked and trended monthly and used by staff to identify and address incidences or trends with member access to a multicultural provider.

There were no member grievances filed for network inadequacies or access to care for 2018. There are no issues or trends identified.

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.

- The top five foreign languages spoken for our membership include Arabic, French, Russian, Spanish, and Vietnamese. An analysis conducted in 2018 of the data shows that members that speak Arabic, French, Russian, Spanish, and Vietnamese as a primary language have access to a primary care provider that speaks the same language. In addition to having providers that speak a member’s language, UHCCP also utilizes a “language line” for interpreter services when interacting with members.
- UHCCP uses the results from data analysis to develop action plans, if necessary, to improve access for ethnic, racial, cultural, and linguistic availability. These reports are taken to quality committees for review and input.
- 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 its 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 continue to share the following actionable information to the provider on its patient population: patient rosters that inform the clinical team of the health status, chronic conditions, and utilization of health care services of its 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.

- Our training includes building relationships with advocate groups and community-based organizations and gaining insight into the social determinants that affect individuals in our community.
- We reach out to local and national partners to present one (1)-hour Lunch and Learn educational sessions so our team can connect Nebraska resources to the needs of the individuals we serve. These education sessions are available to our local, regional and national teams serving our Nebraska Medicaid members, regardless of location. We recognize that our teams impact members’ care, either directly or indirectly, and must have the knowledge and skills to meet the diverse and unique needs of our members. **Table 37** outlines our Lunch and Learn educational sessions to clinical and nonclinical staff in 2018.

Table 37: UHCCP Lunch and Learn Educational Sessions to Clinical and Nonclinical Staff in 2018

Date	Event	Agenda	Topics	Attendees (n)
Jan. 11, 2018	Cancelled: Due to Weather	N/A	N/A	N/A
Feb. 8, 2018	Brain Injury Association of Nebraska  Handouts: PowerPoint and DVD	Overview of agencies and programing  Working with individuals with traumatic brain injury Services	Health Family Social connections Coordination of care	55
Mar. 12, 2018	Project Everlast  Handouts: PowerPoint, brochure and referral forms	Overview How and when to refer Working with former wards and youth aging out of the system	Housing Employment and education Financial assistance Social connections Referral to community services	53
Apr. 10, 2018	Nebraska Consortium for Citizens with Disabilities	Overview of their role and the agencies that take part in the disabilities advocacy group  Discussion around managed care and LTSS and how to work together	Disabilities Housing Employment Advocacy	64
May 14, 2018	League of Human Dignity	Overview of this organization's services and services areas  A brief overview of the DHHS waivers that this organization supports	Housing Advocacy Health Disability	46
June 14, 2018	Bethany Christian Services	Overview and history of the agency  Adoption and foster care services  Working with clients who are choosing adoption	Family Social supports	41
July 12, 2018	Kids Count Report	Overview of the Voice for Children Kids Count annual Report  Presentation of report that looks at demographics of the youth and what services are being utilized	Family Youth Advocacy	43
Aug. 9, 2018	DHHS- LTSS Waivers	Overview of the Traumatic Brain Waiver and the Aged Blind Disabled wavier and how to assist our members in applying	Health Benefits Social supports	51

Date	Event	Agenda	Topics	Attendees (n)
Sept. 13, 2018	Fair Housing Center of Nebraska	Overview of fair housing laws and how we can advocate for our members and how to refer members to fair housing and what the process looks like  Many examples were given by the Fair Housing Center of Nebraska	Housing Health Employment	48
Oct. 11, 2018	Lutheran Family Services – Refugee services	LFS staff went over the programing they offer and how we can assist our members who are refugees and better serve them	Housing Health Social support Transportation	44
Nov. 8, 2018	Human Trafficking-Women Center for Advancement	Overview and information on Human Trafficking and also signs to look for  Discussion of Nebraska being a hub for trafficking because of the location of the state  Discussion of the group’s programing and how to refer to them	Housing Health Social support Employment	54
Dec. 13, 2018	Indian Child Welfare Act (ICWA)	Jill Holt with DHHS went over how ICWA works and how they engage with the tribes, Promise Ship, and Child Protective Services  Talked about the state and federal statues for IWCA	Social support Youth Coordination of care Family	49

LTSS: long-term services and supports; DHHS: Department of Health and Human Services LFS: Lutheran Family Services; ICWA: Indian Child Welfare Act.

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.

- In 2018, UHCCP conducted an educational module on the Indian Child Welfare Act. The presenter discussed how the Act works and how they engage with the tribes, PromiseShip, and Child Protective Services. Additionally, the presenter shared the state and federal statutes for the act.
- The health plan has experienced improved coordination of benefits for our Native American members, including access to providers and offering maternity education, community baby showers, and participating in pow-wows. The health plan initiated a Native American Member Advisory Committee to gain a better understanding of barriers to care, assisting member with social determinants of health, and to continue to incorporate culturally appropriate care delivery. The health plan will continue to foster trust and relationships by hosting community events such as The Good Life in My Moccasins, an outdoor family fair with a goal of connecting Native American families and low-income communities to health care services, including specialty and supportive services.

- 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. Advocates are trained on the following modules:
  - Valuing Diversity and Inclusion,
  - Integrated Behavioral Health,
  - Disability Awareness,
  - Health Literacy,
  - Special Needs Plans,
  - Silver Sneakers,
  - Suicide Prevention,
  - Member Experience – Being accountable to our members,
  - Domestic Violence,
  - Cultural Sensitivity,
  - Trigger Words and Phrases, and
  - Early Intervention.

### 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 a clinical risk stratification tool confirms 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 on our website ([www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)). This training provides easy, accessible, user-friendly tools that can improve the cultural competency of physicians and other health care professionals.
    - In 2018, we communicated in our spring provider newsletter to providers that a member’s right to culturally competent care and members’ cultural and ethnic background and origins are respected. Additionally, UHCCP offers through our online resource library training that discusses why cultural competency and the Americans with Disabilities Act (ADA) requirements are important to care providers, including information on: cultural competency overview, ADA overview, and the provider's role in complying with these requirements. This training is available through UHC-On-Air, which is our source for live and on-demand video broadcasts.
- **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.
  - The tribal liaison provides consultation, technical assistance, education, and outreach to key stakeholders involved in the physical health, behavioral health, and pharmacy needs for the tribal clinics. The tribal liaison collaborates with health plan staff and tribal clinic providers to develop and facilitate health services that are culturally responsive and holistic, and that promote respect for body, mind, and spiritual healing.
  - The health plan’s Provider Relations team has been proactive in supporting and assisting with overcoming trust issues and access to care challenges and educating tribal leaders about managed care business processes. The provider advocates have collaborated with the tribal clinics for billing, coding, claims, and encounters training and education. The health plan has monthly meetings, either by phone or face to face, to cover any questions and education with the tribal clinics.
- **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, and 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.

- The MCO participates in a number of community-based organizational committees to provide insights and support efforts to improve health equity and reduce health disparities, including a member of the Refugee Task Force, Southeast Nebraska Native American Coalition, Nebraska Indian Child Welfare Act Coalition, ARC of Nebraska, South Omaha Community Care Council, Metro Area Continuum of Care for the Homeless, Mexican Consulate, Munroe Meyer Community Advisory Board, Juan Diego Center, and Metro Area Suicide Prevention Coalition. Through the community committee participation, the MCO determined that the ad hoc committee was not needed at this time.
- **Initiative Four:** Implemented a health disparities action plan:
  - UHCCP has a health disparities action plan that supports efforts to reduce health disparities for members and addresses disparities associated with age, gender, address, race and 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.
  - The priorities for the 2017–2019 health disparities plan were revised on 10/28/18 and a newer version for 2019–2020 created. The plan will be presented for review and approval by the Healthcare Quality and Utilization Management (HQUM) Committee and Clinical and Provider Advisory Committee (CPAC). Revised updated priorities for the health disparities plan include:
    - Establishing the foundation for multicultural population stratification;
    - Understanding gaps in health and health care to develop interventions;
    - Refining the patient-centered approach based on member demographics, including race, ethnicity, and language preferences; and
    - Growing multicultural capabilities to enhance the member experience.
- **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, the National Alliance for the Mentally Ill (NAMI), the Metro Area Continuum of Care for the Homeless (MACCH), and others. We will foster trust and relationships by hosting Lunch and 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.
  - See above for the health plan initiatives that impact community engagement for our most vulnerable populations. In 2018, the health plan participated in 594 community events such as health fairs, food pantry distribution, Native American community events, disability focused events, homelessness and housing support events, foster care support events, and more.
  - The MCO has built trusted partnerships with both PromiseShip and the Division of Children and Family Services (DCFS) for children in foster care. Both entities manage the day-to-day care for children removed from their family's homes. UHC clinical coordinators meet weekly with both PromiseShip and DCFS to discuss individual members with complex medical and behavioral health needs to ensure proper coordination of services.
  - The MCO has developed a Housing First plus wraparound services pilot project. The goal of this project is to improve health outcomes and quality of life for chronically ill, homeless members by addressing their social determinants of health. The MCO will partner with Community Alliance, which will provide 10 housing units to

members, rental cost subsidized by UHCCP until permanent housing subsidy is obtained by the individual, and provide wraparound community services to individuals to help them live successfully and independently in the community.

- **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.
  - UHCCP was very active in 2018, connecting with community organizations across the state of Nebraska. In 2018, the health plan hosted 594 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 by 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;
    - ADA training, based upon the National Advisory Board's focus on individuals with disabilities;
    - 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.
  - In 2018, the health plan shared the following information presentations at the quarterly Member Advisory Committee meetings:
    - Integrated health and social services: care management for members;
    - UnitedHealthcare Community Plan's value-added services;
    - Native American traditional healing services;
    - Healthify: Support for social determinants of health;
    - Opioid addiction and recovery program; and
    - Member rewards program.

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. The MCO has also launched additional initiatives for particularly vulnerable populations, such as foster children and homeless members, to provide resources with the goal of improving health outcomes for these members.

## WellCare Health Plan of Nebraska

Throughout the course of 2018, WellCare undertook several community initiatives aimed at addressing healthcare disparities among its membership; this information was provided by the MCO:

## Mini Farmers Markets

In addition to enough healthy food and produce to feed a family of four for a week, participants also received WellCare reusable grocery bags, healthy eating tips and recipes, and a WellCare water bottle to remind them of the importance of staying hydrated. This is a partnership with Foodbank for the Heartland.

- May 31, 2018, at Bright Futures Preschool, Kearney Education Center – Kearney:
  - 121 families (31 WellCare members), 434 individual household members were served. Volunteers from Mid-Nebraska Community Action, Bright Futures, a local Boy Scout troop, and WellCare helped participants gather and transport food.
- November 8, 2018, at Bright Futures Preschool, Kearney Education Center – Kearney:
  - 99 families with a total of 367 family members were served. Volunteers from Bright Futures, University of Nebraska at Kearney, and WellCare helped participants gather and transport food.
- June 21, 2018, at Lakota Lutheran Center, Scottsbluff:
  - 205 families and a total of 695 individuals were served. Volunteers from Lakota Lutheran, Community Action Partnership of Western Nebraska (CAPWN), and WellCare helped participants gather and transport food.
- August 11, 2018, Salvation Army, Norfolk:
  - 136 families and a total of 480 individuals were served.

## Fan Distribution

WellCare donated fans to organizations in Nebraska to help people in need during the extreme heat. Organizations that received fans included:

- Kearney Housing Authority (Kearney),
- CEDARS Prevention & Street Outreach (Lincoln),
- Lincoln Salvation Army (Lincoln),
- People’s City Mission (Lincoln),
- Heartland Health Center (Grand Island),
- Bluestem Health (Lincoln),
- Together Omaha (Omaha),
- Heart Ministry (Omaha),
- Omaha Housing Authority (Omaha),
- Lutheran Family Services (Omaha),
- Community Alliance (Omaha),
- Youth Emergency Services (Omaha),
- Fremont Family Coalition (Fremont),
- Nebraska Urban Indian Coalition (Omaha),
- Mid-Town Health Clinic (Norfolk), and
- Winnebago Tribe (Winnebago).

## Dental Day

Dental Day at the Kearney Welcome Room, in partnership with Bright Futures Kearney Public School and Karla Palmer with MCNA, was a huge success. This was a partnership with MCNA (the dental MCO) and Bright Futures to host a dental event for their monthly social. Twelve (12) families attended the event. Karla (MCNA’s representative) provided information to families with young children on dental hygiene along with new toothbrushes. Jennifer (WellCare’s representative) talked about the benefits of dental hygiene on our overall health and shared information about the WellCare 2018 healthy reward for the dental check (in 2018, members could receive a Visa gift card for attending their annual dental appointment).

## Youth Behavioral Health Support Groups

- WellCare Health Plan of Nebraska has partnered again with Families CARE in Kearney, Nebraska, to host a support group for youth ages 13–26. This partnership has grown and now offers the youth support groups in Grand Island, Nebraska, as well as Kearney, Nebraska, at the local Welcome Room. This is a great opportunity to support youth and offer fun, educational opportunities in both communities.
- The Zone “Brave Girls” Group an afterschool group of girls from 7–12th grade in Norfolk, Nebraska. The group discussed the importance of taking care of your mental health in their age group, what things in their lives cause

stress, and how they choose to cope with that. The group also made homemade bath salts and left with goodie bags containing stress balls, dry erase calendars, ear buds, lip balm, and compact mirrors. Fifteen (15) young women were in attendance.

### **Cold Weather Donations for Seniors**

WellCare donated blankets, hat and scarf sets, and warm socks to organizations across the state supporting low-income seniors. Organizations supported:

- Heart Ministry (Omaha) – approximately 150 seniors received hats and scarves;
- Catholic Charities (Omaha) – approximately 50 seniors received warm blankets;
- Intercultural Senior Center (Omaha) – 120 cold-weather bags with wool socks, snacks, and hand sanitizer donated;
- Lincoln Housing Authority (Lincoln) – approximately 50 seniors received warm blankets;
- Kearney Housing Authority (Kearney) – approximately 50 seniors received warm blankets;
- Norfolk Senior Center (Norfolk) – approximately 50 senior citizens received hats and gloves, and the WellCare staff also stayed and helped serve lunch;
- Shalimar Assisted Living (Fremont) – more than 80 residents received blankets;
- Lakota Lutheran Center (Scottsbluff) – 50 blankets donated; and
- CAPWN (Scottsbluff) – 50 blankets donated.

### **Cooking Classes**

- Provided healthy eating and cooking on a budget classes at the Omaha Welcome Room for surrounding community. All food used could be found at Together Omaha food pantry. Also provided cooking demonstrations at local events (Fall Festival at Nebraska Urban Indian Coalition) and onsite at the Together Omaha pantry.

### **Targeted Baby Showers**

- Omaha – Collaboration with Lutheran Family Services. WellCare hosted two (2) baby showers supporting the refugee communities; one (1) for Karen families (about 40 participants) and one (1) for Afghan women (10 participants); and
- Tribal Communities – one (1) baby shower focused on “Purple Crying” at the Santee Sioux Health Clinic.

### **Care Management**

The work to include social determinants in the algorithm score for care management referral continues for WellCare Health Plan of Nebraska. As an organization, WellCare is currently exploring the appropriate platform in which to gather these data from internal and external sources to be able to incorporate into its existing IT platform. The MCO has engaged with the state’s health information exchange (NEHII) to receive and incorporate continuity of care documents (CCD; considered the standard format for sharing data between health organizations) to facilitate this process, as well as be an engaged partner as they work to develop a community-based care plan functionality in their platform.

Every member who engages with care management is screened for disparities in addition to screening for physical and behavioral health needs.

Any member admitted to an inpatient facility who has identified social determinants impacting his or her care is referred by the utilization management team to care management for outreach.

WellCare has a designated care manager who acts as its housing coordinator.

CM leadership continues to participate in the CMS Innovation Accelerator Program (IAP). The formal CMS IAP grant project has concluded; however, work continues with the cross-functional team to address housing needs in the state for the identified population. These meetings occur once per quarter.

NE Special Olympics Medical Advisory Committee had postponed further meetings while awaiting CMS’s reply to DHHS regarding the new developmental disabilities (DD) waiver. Meetings resumed 7/2018. WellCare continues to participate in committee meetings.

## Assessment of MCO Follow-up on Prior Recommendations

### MCO Response to Reporting Year 2018 EQR Recommendations

Federal EQR regulations for external quality review results and detailed technical reports at §438.364 require that the EQR include in each annual report an assessment of the degree to which each MCE has addressed the recommendations for quality improvement made in the prior EQR technical report. The following section provides an assessment as to the degree to which the MCOs effectively addressed the improvement recommendations made by IPRO during the previous year (note MCNA is not included, as this is the first year of reporting for the DBPM). See **Table 38** for an assessment of NTC’s response to prior year recommendations. See **Table 39** for an assessment of UHCCP’s responses to prior year recommendations. See **Table 40** for an assessment of WellCare’s response to prior year recommendations.

#### Nebraska Total Care

Table 38: Assessment of NTC’s Response to Prior Year Recommendations

Domain	IPRO Recommendation for RY 2018	IPRO Assessment of Compliance
Quality	Track and measure 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.
Quality	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.	The language sheet and statement of non-discrimination has been included as an attachment to policy NE.MBRS.02.
Quality	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.	NTC staff is aware of the requirement, and the MCO does have this documentation in their internal systems as it is part of the daily workflow. This requirement was fully met upon subsequent compliance review in May 2018.
Quality	In cases of verbal inquiries seeking to appeal, confirm these inquiries in writing.	NTC’s policies and procedures outline the appropriate process by which MCO staff ensures verbal inquiries are confirmed in writing.
Quality	Include language in appeal files that states that the member can present evidence in person.	Corrections were made to the letter and upon subsequent compliance review in 2018 this requirement was fully met.
Quality	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).	Language was incorporated into the member handbook that included QAPI information, how to become a member of one of NTC’s quality committees, and information about NTC’s annual evaluation and how the member can access this information (by phone or website).
Quality	Include member addresses within the MAC report that is submitted semiannually to MLTC.	Addresses were not included within the report reviewed during the 2018 audit, however NTC is currently collecting member addresses and will submit on the next semiannual report to MLTC.
Quality	Report utilization by race, ethnicity, gender, and age, and make this report available for review during the subsequent (2018) compliance audit.	NTC revised Policy NE.UM.01.03 to reflect language. Monitoring includes services at all levels of care, and utilization of services by race, ethnicity, gender, and age. This policy will be

Domain	IPRO Recommendation for RY 2018	IPRO Assessment of Compliance
		submitted upon next IPRO review (in 2019).
<b>Quality</b>	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.	NTC provided the off-label denial report during the 2018 compliance audit.
<b>Quality</b>	Provide a report that monitors emergency services utilization by provider and member, and have methods for addressing inappropriate utilization.	NTC provided an ED utilization report during the 2018 compliance audit that demonstrated monitoring of emergency services utilization and methods for addressing inappropriate utilization.
<b>Quality</b>	Ensure that pre-delegation evaluation is conducted and documented.	NTC was found in full compliance with this item during the 2018 audit.
<b>Quality</b>	Establish an ongoing and annual audit schedule and convene a vendor management committee to review the results of each vendor audit.	NTC was found in full compliance with this item during the 2018 audit.
<b>Access</b>	Include the assigned risk stratification level within the care management files.	NTC was found in full compliance with this item during the 2018 audit.
<b>Access</b>	Include evidence of collaboration and communication with other providers in the care management file, as appropriate to the member's needs.	NTC was found in full compliance with this item during the 2018 audit.
<b>Access</b>	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.	NTC is examining use of psychotropic medication in youth that includes identification and sharing of best practices to achieve higher medication adherence rates.
<b>Access</b>	Develop staff training specific to barriers members may experience in making and keeping appointments.	NTC has adopted the Centene community health training course, and thus fully met this requirement during the 2018 audit.
<b>Access</b>	Have a process in place to monitor and reduce appointment "no-show" rates by provider and service type.	NTC developed Policy NE PRVR 53 to outline the process for monitoring and reducing no-show appointments.
<b>Access</b>	Have a process in place to monitor waiting lists for members who seek covered services.	NTC developed monthly wait and ward reports.
<b>Access</b>	Continue its recruiting efforts to increase adequacy in the areas lacking access. NTC should work with MLTC to address gaps in adequacy.	NTC was found in full compliance with this item during the 2018 audit.

IPRO: Island Peer Review Organization; RY: reporting year; I/T/U: Indian health services, tribal health providers, and urban Indian health providers; NTC: Nebraska Total Care; QAPI: Quality Assessment and Performance Improvement; QI: Quality Improvement; MAC: Member Advisory Committee; MTLC: Medicaid and Long-Term Care; ED: emergency department.

## UnitedHealthcare Community Plan

Table 39: Assessment of UHCCP's Response to Prior Year Recommendations

Domain	IPRO Recommendation for RY 2018	IPRO Assessment of Compliance
<b>Quality</b>	Provide members with verbal notice of delay when the timeframe for appeal resolution is extended.	The MCO has updated documentation to include verbal notice of the delay to the member via phone call. Staff training is ongoing.
<b>Quality</b>	Provide a report that details mechanisms to ensure consistent application for review criteria for authorization decisions during each annual compliance audit.	All licensed employees who are involved in the prior authorization process must complete the inter-rater reliability testing at least annually. The testing was completed with 100% of the staff passing the

Domain	I PRO Recommendation for RY 2018	I PRO Assessment of Compliance
		testing.
<b>Quality</b>	Provide utilization reports that include demographic stratification by race, ethnicity, and gender during each annual compliance audit.	UHCCP’s Hotspotting tool has been updated to provide enhanced member demographics, including age, gender, race, ethnicity, language, and geographic location.
<b>Quality</b>	Ensure that UM denial files include evidence of a written notice of action provided to the member.	The 2018 NE audit report received documented a finding that one (1) of 10 UM denial files reviewed did not include evidence that the member received a notification letter. Upon further research, it was identified that this is a NE Medicare Dual SNP member, and an appropriate denial notification was sent. The Dual SNP file should not have been included in the universe for this audit. The MCO will conduct quality reviews on the UM medical universe to ensure that only the appropriate membership is included in the submitted universe.
<b>Access</b>	Develop staff training specific to barriers members may experience in making and keeping appointments. UHCCP may consider using its web-based tutorial, LearnSource.	“How to Address Doctor Appointment Barriers” was developed and deployed to Health Services staff through the MCO’s learning platform in 2018.
<b>Access</b>	Partner directly with provider practices that demonstrate higher medication adherence rate.	The MCO provides education with provider practices through the recording and videos posted on UHC on Air, the MCO’s Providers EXPOs, and monthly meetings with providers. The MCO also uses the policies and procedures that are posted on www.UHCProvider.com and facilitates Webex meetings with provider practices on a regular basis.
<b>Access</b>	Ensure that all file documentation includes a risk stratification level, and evidence of monitoring of progress towards individualized care plan goals.	Low, medium, and high outreach is completed by the clinical coordinators. Clinical coordinators are then provided feedback on charting during their one-on-ones with their managers, who perform chart audits of clinical staff on a routine basis.

I PRO: Island Peer Review Organization; RY: reporting year; MCO: managed care organization; UHCCP: UnitedHealthcare Community Plan; NE: Nebraska; UM: Utilization Management; SNP: special needs plan.

## WellCare Health Plan of Nebraska

Table 40: Assessment of WellCare’s Response to Prior Year Recommendations

Domain	I PRO Recommendation for RY 2018	I PRO Assessment of Compliance
<b>Quality</b>	Track and measure I/T/U provider adequacy to ensure timely access for eligible members.	WellCare was found fully compliant with this standard for the 2018 audit. WellCare provided claim reports demonstrating the utilization of I/T/U providers, as well a list of members attributed to I/T/U providers as PCPs.
<b>Quality</b>	Make the Spanish version of the member handbook available online to members.	Both English and Spanish versions of the member handbook are available online to members.
<b>Quality</b>	Include information about WellCare’s QAPI program in the member handbook and/or the MCO website.	WellCare was found in full compliance with this item during the 2018 audit.
<b>Quality</b>	Submit the MAC report to MLTC which clearly	This item has been met and found fully compliant

Domain	IPRO Recommendation for RY 2018	IPRO Assessment of Compliance
	differentiates between WellCare members and staff, and also includes the addresses of members, per the contract requirement.	during the 2018 audit.
<b>Quality</b>	Provide a written notice of action to members which includes notice of the member's right to request a state fair hearing.	The Notice of Adverse Benefit Determination letter includes the member's right to request a state fair hearing. This information is also included in the member handbook.
<b>Quality</b>	Include acknowledgment letters in all grievance files.	During the 2018 audit, all grievance files contained acknowledgement letters.
<b>Quality</b>	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.	All files reviewed for the 2018 audit were found in full compliance with this requirement.
<b>Quality</b>	Ensure that all appeals files contain results and date of the appeal resolution.	All files reviewed for the 2018 audit contained the results and the date of appeal resolution and were found in full compliance with this requirement.
<b>Quality</b>	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.	This is addressed in WellCare policy, and the MCO was in full compliance with this requirement during the 2018 audit.
<b>Quality</b>	Consider issuing an addendum to the Advanced Medical Review (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.	WellCare was found in full compliance with all subcontractor oversight items during the 2018 audit.
<b>Quality</b>	Provide a clear narrative to guide the EQRO in the case of name changes for any of the subcontractors.	WellCare was found in full compliance with all subcontractor oversight items during the 2018 audit.
<b>Quality</b>	Submit documentation pertaining to pre-delegation review within the case file for each subcontractor within the review period.	WellCare was found in full compliance with all subcontractor oversight items during the 2018 audit.
<b>Quality</b>	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 was found in full compliance with all subcontractor oversight items during the 2018 audit.
<b>Quality</b>	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.	WellCare was found in full compliance with all subcontractor oversight items during the 2018 audit.
<b>Quality</b>	Consider changes to their delegation oversight procedure to designate a single staff person within the Nebraska team who will be responsible for following up with corrective action plans (CAPS) and reporting back to the Delegation Oversight Committee.	WellCare was found in full compliance with all subcontractor oversight items during the 2018 audit.

Domain	IPRO Recommendation for RY 2018	IPRO Assessment of Compliance
<b>Timeliness</b>	Provide a written notice of action to members within specified timeframes.	This requirement is addressed in WellCare policy and WellCare was found in full compliance with this standard during the 2018 audit.
<b>Access</b>	Ensure that all care management files include the assigned risk stratification level.	For the 2018 audit, WellCare was found to be substantially compliant. WellCare agrees that risk stratification is an important component of the CM process. WellCare will evaluate our internal documentation process to ensure that stratification levels are included in files.
<b>Access</b>	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.	WellCare was found in full compliance with this item during the 2018 audit.
<b>Access</b>	Develop staff training specific to barriers members may experience in making and keeping appointments.	WellCare was found in full compliance with this item during the 2018 audit.
<b>Access</b>	Continue its efforts to increase adequacy in frontier areas. WellCare should work with MLTC to address gaps in adequacy.	WellCare is in full compliance with all access standards related to frontier areas.

IPRO: Island Peer Review Organization; RY: reporting year; I/T/U: Indian health services, tribal health providers, and urban Indian health providers; PCP: primary care provider; QAPI: Quality Assessment and Performance Improvement; MAC: Member Advisory Committee; MLTC: Medicaid and Long-Term Care; AMR: Advanced Medical Review; EQRO: external quality review organization; CAPS: corrective action plans.

## 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 delineate 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 (3)-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 (3)-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 (3)-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 MCO's 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; and
- 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 September 2017–March 2018, conducted in May 2018, addressed contract requirements and regulations within the following categories:

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

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

### 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., substandards). The tools include the following:

- statement of federal regulation and related federal regulations;
- statement of state regulations;
- statement of state and MCE contract requirement(s);
- suggested evidence;
- reviewer determination;

- prior results (based on Readiness Review);
- descriptive reviewer findings and comments related to findings; and
- MCE 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**

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

MCE: managed care entity.

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

**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 MCE 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 MCEs. Prior to the review, a notice was sent to the MCEs 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, walk-throughs 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 **Pre-onsite Activities**, in advance of the review, IPRO requested documents relevant to each standard under review to support each MCE’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 2018 review is included in **Compliance Monitoring** in this report.

### **Data Aggregation and Analysis**

**Post-onsite Activities** – Following the onsite review, the MCEs 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 MCE. For standards where an MCE was less than fully compliant, IPRO provided in the review tool a narrative description of the evidence reviewed and reason for non-compliance. Each MCE 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 MCE and made final review determinations.

## Appendix B: Validation of Performance Improvement Projects

### Objectives

Medicaid MCEs implement 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 and 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 10 elements:

- review of the selected study topic(s) for relevance of focus and for relevance to the MCE’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 MCE enrollment and generalizable to the MCE’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 were 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; and
- assessment of whether the MCE 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 initiated in 2018, a review of final 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, “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 10 protocol elements is considered.

### Description of Data Obtained

Each PIP was validated using the MCE’s PIP project reports, and in collaboration with DHHS’s data and analytics team (to validate statewide, averages compare state-collected MCE rates against what the MCEs 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. Because only PIP proposals were available for evaluation in MY 2017, followed by an update report for MY 2018, analysis included review of the study topic, questions, indicators, target population, data collection procedures, and interventions. 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.

## Appendix C: Validation of Performance Measures

### Objectives

Medicaid MCEs calculate performance measures to monitor and improve processes of care. As per the CMS regulations, validation of performance measures is one of the mandatory EQR activities.

The primary objectives of the performance measure validation process are to assess the:

- MCE's process for calculating performance measures and to determine whether the process adhered to the specifications outlined for each measure; and
- accuracy of the performance measure rates, as calculated and reported by the MCE.

### Technical Methods of Data Collection

The methodology for validation of performance measures is based on the CMS protocol, "Validating Performance Measures." As an NCQA-accredited health plan, the MCO reports HEDIS rates to NCQA that are audited by an independent NCQA-licensed HEDIS Compliance Audit Firm. IPRO requested copies of the auditor-submitted final HEDIS compliance audit report, as well as the final rates for validation. Using the findings of the audit report, IPRO evaluated the MCO's information systems capabilities, audit designation findings, and any issues that precluded accurate reporting.

### Description of Data Obtained

Performance measures were validated using the MCO's final HEDIS compliance audit report and final rates. In addition, production of performance measures is periodically discussed with the MCOs during conference calls and during the annual compliance review.

### Data Aggregation and Analysis

NCQA-certified HEDIS compliance auditors validated each MCO's reported HEDIS performance measures. IPRO used the audit reports as a basis for its evaluation. Measure validation included the following steps:

- IPRO reviewed the FAR of the HEDIS results reported by the MCO that was prepared by an NCQA-licensed organization to ensure that appropriate audit standards were followed. The NCQA *HEDIS Compliance Audit: Standards, Policies and Procedures* document outlines the requirements for HEDIS compliance audits and was the basis for determining the accuracy of the findings stated in the FAR.
- IPRO used available national HEDIS benchmarks, trended data, and knowledge of the MCO's quality improvement activities to assess the accuracy of the reported rates.
- The MCO's interventions to improve quality were reviewed to determine whether the interventions were successful in enhancing care, as measured by any change in the performance measure rate from year to year. Based upon this review, IPRO made recommendations as to whether the MCO should retain or modify its improvement activities.

To ensure that the performance measures calculated by the MCO met the CMS protocol requiring MCOs to measure quality, timeliness and access of care, IPRO designed a matrix that assigned each performance measure to one or more of the three domains.

Subsequent to the validation process, a report of the findings and our recommendations was prepared and included in the technical report.