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DEPT. OF HEALTH AND HUMAN SERVICES

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

Quality Strategy for Heritage Health and the Dental Benefit Program 2020

Nebraska Department of Health and Human Services
http://dhhs.ne.gov

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Introduction

Development and Review of Quality Strategy

The Quality Strategy was developed across various units within Medicaid and Long-Term Care (MLTC), and in collaboration with Nebraska Department of Health and Human Services' (NE DHHS's) external quality review organization (EQRO), Island Peer Review Organization (IPRO). This document is modified or updated when significant changes, defined as substantial programmatic changes (such as incorporating new populations into the Nebraska Medicaid Managed Care [MMC] Program) are implemented. The Quality Strategy will also be updated when quality indicators suggest that new or different approaches must be implemented to improve the quality of care of enrollees. Those involved with creating this strategy intend to make it available for public comment on MLTC's state website at http://dhhs.ne.gov/Pages/Medicaid-Public-Notices.aspx . It is also the intention of the document creators that it is presented to the Medical Assistance Advisory Council and the Quality Management Committee to obtain stakeholder input.

Milestones of Nebraska Medicaid Managed Care

The state of Nebraska's Children's Health Insurance Program (CHIP) and Medicaid programs are administered by the MLTC Agency within NE DHHS. 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 MMC program for physical health, behavioral health, 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 physical health and one for mental health and substance use disorders (SUDs), with full-risk behavioral health managed care effective September 2013. In October 2015, following a request for proposal (RFP) for their new integrated MMC Program, referred to as Heritage Health, NE DHHS contracted with three managed care organizations (MCOs) to each provide physical health care, behavioral health care, and pharmacy services for their Medicaid and CHIP enrollees, beginning January 1, 2017. Notable changes associated with the implementation of this program include the integration of physical and behavioral health care through three MCO contracts for all 93 counties in the state of Nebraska; inclusion of pharmacy services in the core benefit package and the MCO capitation rate; inclusion of the aged, blind and disabled (ABD) populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services; and the expansion of enrollment broker services to complete the process of member enrollment. Another program implemented by NE DHHS MLTC in 2017 transitioned Nebraska's fee-for-service (FFS) dental program into a managed care delivery system. This new program, which began on October 1, 2017, is administered by a prepaid ambulatory health plan (PAHP) that contracts with MLTC for the delivery of Medicaid dental benefits and services. Beginning July 2019, non-emergency medical transportation (NEMT) services were carved into the Heritage Health Program, thereby allowing the MCOs to further integrate and coordinate care for their members.

In 2018, Nebraska's voters approved Medicaid Expansion via Initiative 427, which will provide Medicaid coverage to otherwise ineligible adults up to 138% of the federal poverty level under the provisions of the Patient Protection and Affordable Care Act (PPACA). This expansion is slated to go live October 2020. In order to implement this adult expansion program, Nebraska Medicaid is seeking approval to modify its current managed care program by creating the Heritage Health Adult (HHA) Program. The HHA Program will implement Initiative 427 and achieve the goals of the Quadruple Aim to improve the member experience of care, the provider experience, the health of populations, and reduce the per-capita cost of health care. The Quadruple Aim governs MLTC's quality strategy, and is the framework through which MLTC is advancing managed care to a higher quality standard.

Managed Care Goals and Objectives

The Heritage Health Program was designed to simplify the delivery model for Medicaid recipients, by integrating physical health benefits and behavioral health benefits into a single health plan. Being that mental illness and SUDs often co-occur with chronic conditions such as heart disease, cancer, and diabetes, having one health plan responsible for the full range of services for a recipient encourages investment in more cost-effective services to better address the health care needs of the whole person. This integration allows important information to become available to the care management (CM) team, allowing health care managers to identify individuals who may be at risk and facilitate earlier intervention, along with decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. Similar to the Heritage Health Program, the Dental Managed Care Program includes important initiatives aimed at improving care coordination, as well as access to dental care for Medicaid eligible individuals. The contracted dental benefits program manager (DBPM) is responsible for establishing a dental home program that strengthens the provider-patient relationship, encourages the utilization of preventative services, and promotes positive patient education.

The goals and objectives for the Heritage Health Program directly reflect the Quadruple Aim of improving member experience of care, provider experience, the health of populations, and reducing the per-capita cost of health care. MLTC seeks to achieve the following goals under this integrated physical and behavioral health system:

- improve health outcomes;
- enhance integration of services and quality of care;
- put emphasis on person-centered care, including enhanced preventive and CM services (focusing on the early identification of members who require active CM);
- 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 our diverse clients.

In terms of oral health, MLTC seeks to achieve the following goals under the dental PAHP:

- improved access to routine and specialty dental care;
- improved coordination of care;
- better dental health outcomes;
- increased quality of dental care;
- outreach and education to promote dental health;
- increased personal responsibility and self-management; and
- overall savings to the Nebraska Medicaid program by preventing treatable dental conditions from becoming costly medical conditions.

This Quality Strategy outlines the mechanisms by which MLTC will meet these goals through the assessment of the quality and appropriateness of care via performance improvement and measurement, state standard compliance monitoring, and external quality review (EQR), interventions that MLTC is undertaking to improve quality of care to MMC members, and delivery system reform initiatives that MLTC has both implemented and planned.

Quality Assurance and Quality Improvement

Quality and Appropriateness of Care

MLTC has implemented systems for the ongoing assessment of the quality and appropriateness of care and services furnished to all Medicaid enrollees under the Nebraska Medicaid MCO contracts. These systems enable MLTC's monitoring of data related to the access of Medicaid clients to comprehensive, cost-effective health services, including evidence-based care options that emphasize early intervention and community-based treatment as well as reduced rates of costly and avoidable emergency and inpatient hospital levels of care. Through the implementation of these assessment systems, MLTC can monitor trends, demonstrate success and identify challenges in achieving the objectives of the Quadruple Aim.

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

- quarterly reporting of provider accessibility analyses, timely access standards monitoring, grievances and appeals process compliance, utilization management (UM) monitoring, results of service verification monitoring, out of network referrals monitoring and case management results;
- annual reporting of MLTC-selected performance measures (PMs), results and trends related to quality of care, service utilization and member and provider satisfaction;
- annual reporting of performance improvement project (PIP) data and results;
- annual, external independent reviews of the quality outcomes, timeliness of and access to, the services covered by the MCO through its EQRO;
- annual state-staff-conducted onsite operational reviews that include validation of reports and data previously submitted by the MCO and in-depth review of areas that have been identified as potentially problematic; and
- MLTC requirement that MCOs to attend Quality Management Committee meetings, during which data and information designed to analyze the objectives of the Quality Strategy are reviewed.

In addition, MLTC assesses the quality and appropriateness of care provided by the DBPM, demonstrated by the following protocols:

- MLTC and CMS (Center for Medicare & Medicaid Services) may inspect and audit any records of the DBPM or its subcontractors. There is no restriction on the right of MLTC or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.
- The DBPM's quality assessment and performance improvement (QAPI) program objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities. The results of these activities are reported to MLTC annually.
- The DBPM conducts annual member satisfaction surveys to assess the quality and appropriateness of care to members each contract year.
- The DBPM's policies and procedures include the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, and efficiency of dental care services. Policies and procedures provide guidance for assessing the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

National Performance Measures

The MCOs report all CMS adult and child core measures, while the DBPM reports a combination of child core, Healthcare Effectiveness Data and Information Set (HEDIS®), and Dental Quality Alliance (DQA) measures (**Table 1**). MLTC and/or CMS may update performance targets, including choosing additional PMs or removing PMs from the list of requirements, at any time during the contract period.

Performance measurement is a key tool that MLTC uses to monitor the MMC program and to continue to improve quality of care over time. The reporting of PMs allows MLTC to assess the quality of care currently being delivered to Nebraska's Medicaid recipients and to trend performance from year to year.

The Heritage Health measure set requires MCOs to collect and report measures that include the following areas of care:

- screening and preventive care (e.g., cervical cancer screening, childhood immunizations);
- chronic care (e.g., asthma and diabetes management);
- maternity care (e.g., prenatal and postpartum visits);
- access, availability and timeliness of care (e.g., access to primary care well-child visits);
- utilization (e.g., emergency department utilization, chronic care admissions); and
- satisfaction with and experience of care (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS®]: satisfaction with physician and health plan).

With the implementation of the Heritage Health Program, contracted MCOs are required to attain NCQA accreditation. Standardized accreditation combined with the integration of physical and behavioral health programs, allows the state to better evaluate quality performance and provides for a clearer comparison between MCOs.

Table 1: DBPM Performance Measures

DBPM Performance Measures
Child Core Measures
Percentage of Eligible Population who Received Preventive Dental Services (PDENT)
HEDIS Measures
Annual Dental Visit
Dental Quality Alliance Measures
Percentage of Enrolled Children who Received at Least One Dental Service Within the Reporting Year
Percentage of Enrolled Children who Received a Treatment Service as a Dental Service Within the Reporting Year
Percentage of Enrolled Children who Received a Comprehensive or Periodic Oral Evaluation as a Dental Service Within the Reporting Year
Percentage of Children Enrolled in Two Consecutive Years who Received a Comprehensive or Periodic Oral Evaluation as a Dental Service in Both Years

DBPM: dental benefits program manager; HEDIS: Healthcare Effectiveness Data and Information Set.

Heritage Health Managed Care Organization Quality Reporting Requirements

- The MCO must report on the CMS adult core, child core, CAHPS, and HEDIS measures, as well as additional PMs as determined by MLTC. Measures may be removed or added at will by MLTC, and MCOs are given a 60-day period in which to implement additional measure requirements. The MCOs will report using the most current version, specification, or manual that is available prior to required reporting deadlines, as is related to the given measure set. The MCOs may request exemption from reporting specific measures within respective sets due to inability to report, subject to MLTC approval, within a MLTC designated schedule.
- MLTC may utilize a hybrid or other methodology for collecting and reporting PM rates, as allowed by the NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects is based on the HEDIS, EQR or other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC, upon request, with its methodology for calculating PMs.
- The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan (CAP) and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.
- The MCO must report results of measuring or assessing outcomes and quality, and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the MCO's QAPI Committee and approved by MLTC.
- Any outcomes and PM results that are based on a sample of member, family, or provider populations must

demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.

- The MCO must report to MLTC on a quarterly basis the minutes and disposition of quality program initiatives that were presented to the QAPI Committee to ensure that all quality initiatives are reviewed at the frequencies outlined in the MCO's Quality Management (QM) Program Description.

DBPM Quality Reporting Requirements

- The DBPM must report on PMs listed in **Table 1**, which include, but are not limited to, HEDIS, CMS, and DQA measures, and other measures as determined by MLTC.
- Clinical PM outcomes must be submitted to MLTC at least annually and upon MLTC request.
- Administrative PMs must be submitted to MLTC at least quarterly and upon MLTC request.
- The reports and data must demonstrate adherence to clinical practice guidelines and must demonstrate changes in patient outcomes.
- The DBPM must provide individual dental home clinical quality profile reports.
- During the course of the contract, MLTC or its designee will communicate with the DBPM regarding the data and reports received as well as meet with representatives of the DBPM to review the results of PMs.

Quality Programs and Compliance Monitoring

In order to attain the goals set forth in this Quality Strategy, and to maintain oversight of managed care entity (MCE) compliance with access, structure and operations, and measurement and improvement standards, MLTC conducts several monitoring activities. Mechanisms used for monitoring include the Quality Performance Program (QPP), Heritage Health Quality Reporting Requirements, PIPs, and EQR including compliance review and PM validation. It should also be noted that CMS, in consultation with states and other stakeholders is in the process of identifying PMs and a methodology for an MMC quality rating system that aligns with the summary indicators of the qualified health plan quality rating system. The state will implement such a system within three years of the date of a final notice published in the Federal Register.

Data Collection

The state requires that each MCE undertake various data collection and reporting activities to help assess the quality and appropriateness of care delivered under the MMC program. Further, to help identify disparities of care and to promote interventions to reduce them, the state requires the MCE to collect data on the special health care needs (SHCN) population as well.

- The MCE must collect performance data and conduct data analysis with the goal of improving members' quality of care. The MCE must document and report to the state its results on PMs chosen by MLTC (and/or CMS) to improve quality of care and health outcomes.
- Data analysis must consider the MCE's performance in the previous year, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCE must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCE's encounter data system. The MCE must ensure that data received from providers are accurate and complete by:
    - verifying the accuracy and timeliness of reported data;
    - screening the data for completeness, logicalness, and consistency; and
    - collecting service information using MLTC-developed templates.
- The MCE's data analysis process must be able to identify and resolve system issues consistent with a continuous quality improvement (QI) approach.
- The MCE is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for PMs and PIPs must be submitted by the MCE in a format and due date specified by MLTC. Any extension necessary to collect and report data must be submitted in writing to MLTC in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCE per Section IV.V Contract Non-compliance.

Quality Performance Program

The MCEs participate in the MLTC QPP, which is implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes. Neb. Rev. Stat. 71-831 is provided as **Appendix A: Neb. Rev. Stat. 71-831**. Pursuant to this statute, the MCE must hold back 1.5% of the aggregate of all income and revenue earned by the MCE and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the MCE to earn via the QPP. QPP measures for which the MCO is eligible to earn hold-back funds are included in **Appendix B: Heritage Health MCO Quality Performance Program Measures**. QPP measures for which the DBPM is eligible to earn hold-back funds are included in **Appendix C: DBPM Quality Performance Program Measures**.

The MCE must report its PMs that affect the MCE's eligibility to earn hold-back funds monthly, quarterly, semi-annually (DBPM only) and annually, and upon the request of MLTC. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC assesses the MCE's performance based on the measures annually and notify the MCE of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC makes this determination within 11 months after the end of each contract year. All earned hold-back funds become the property of the MCE. The MCE must deposit unearned (forfeited) hold- back funds to MLTC. MLTC reimburses the federal share of the forfeited funds to CMS, and the remaining state share of the forfeited hold-back funds is retained by MLTC. No interest is due to either party on hold-back funds retained by the MCE or returned to MLTC.

MLTC reserves the right to modify annually the measures and criteria for earning the hold-back funds. In the event that MLTC modifies the measures or criteria, MLTC will provide the MCE a written notice 60 calendar days in advance. These measures will include operational or administrative measures that reflect MCE business processes and may lead to improved access to and quality of care, CMS Medicaid adult and child core measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement as indicated by Heritage Health historical performance. Any earned hold-back will not be included in the MCE's income for the year nor considered part of the medical loss ratio (MLR) calculation.

Performance Improvement Projects

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

MCOs

Each MCO must conduct a minimum of two clinical and one non-clinical PIP. A minimum of one clinical topic must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health care outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. The MCO must participate in a minimum of one joint PIP with the other MCOs; the topic is identified by MLTC or its designee. PIPs must meet all relevant CMS requirements and be approved by MLTC or its designee prior to implementation. Furthermore, CMS may specify a PIP topic, which must be included in the PIPs required by the state.

DBPM

The DBPM must conduct a minimum of one clinical and one non-clinical PIP. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.

PIP Requirements

- PIPs must be addressed in the MCE's annual QM Program Description, Work Plan, and Program Evaluation.
- The MCE must report the status and results of each project to MLTC, and must comply with CMS requirements, including:
  - a clear study topic and question as determined or approved by MLTC;
  - clear, defined, and measurable goals and objectives that the MCE can achieve in each year of the project;
  - a study population;
  - measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow

tracking of performance over time;
  - the MCE must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices;
  - the MCE must use measures that are based on current scientific knowledge and clinical experience; qualitative or quantitative approaches may be used as appropriate;
  - the methodology for evaluation of findings from data collection;
  - implementation of system interventions to achieve QI;
  - a methodology for the evaluation of the effectiveness of the chosen interventions;
  - documentation of the data collection methodology used (including sources) and steps taken to ensure the data are valid and reliable; and
  - planning and initiation of activities for increasing and sustaining improvement.
- The MCE must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.
- The MCE must implement the PIP recommendations on approval by MLTC and the MCE's QAPI Committee.
- Each PIP must be completed in a reasonable time period to allow the results to guide its QI activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCE's QAPI program.
- CMS, in consultation with the state and other stakeholders, may specify additional PIPs (and PMs included in PIPs) to be undertaken by the MCE.
- MLTC reserves the right to request additional reports from the MCE. The MCE is notified of additional reporting requirements no less than 30 calendar days prior to the due date of a report.

Quality Assessment and Performance Improvement

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

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

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

External Quality Review

NE DHHS has contracted with IPRO as an EQRO to conduct EQR of the contracted MCEs under the Heritage Health Program. IPRO is a national health care assessment organization that is licensed to conduct HEDIS compliance audits by the NCQA, and is accredited by URAC, amongst others. The MCE is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to services covered under the contract, per 42 CFR 438.350. NE DHHS contracts with its EQRO to prepare an annual technical report (ATR) for each MCE, which includes a compendium of plan-specific descriptive data reflecting the CMS protocols for EQR reports. Analysis within the report includes validation of PMs, compliance with access standards, structure and operation standards, and validation of PIPs. The EQRO compiles a profile for each plan, including a summary of strengths and opportunities. With this analysis in mind, each year NE DHHS and the EQRO reassess each MCE's progress in addressing and improving identified problem areas. In order to avoid duplication of mandatory EQR activities, MLTC may use information about the MCE obtained from a private accreditation review to provide information otherwise obtained from the mandatory activities specified in 42 CFR 438.358.

Intermediate Sanctions

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

Sanction Types

MLTC may impose the following intermediate sanctions at its sole discretion:

- civil monetary penalties as specified in Section IV.V Contract Non-Compliance of the Heritage Health contract;
- appointment of temporary management (as described in **Special Rules for Temporary Management** section below);
- granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;
- suspension of all new enrollments into the MCE, including auto-assignments, as of the effective date of the sanction;
- suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and
- any other remedy, right, or sanction allowed under the contract or applicable law.

Special Rules for Temporary Management

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

State Standards for Program Compliance

In accordance with CMS requirements (42 CFR 438.66), MLTC, or its designee, will conduct Annual Operational Reviews to ensure program compliance and identify best practices. The reviews identify and make recommendations for areas of improvement, monitor the MCE's progress towards implementing mandated programs or operational enhancements, and provide the MCE with technical assistance when necessary. The following sections describe the standards that are reviewed as part of compliance:

- Access Standards,
- Utilization Management Standards,
- Structure and Operations Standards,
- Grievance System Standards,
- Subcontracting Standards, and
- Care Management Standards.

Access Standards

MLTC's approach to promoting quality includes an assessment of MCE compliance with federal and state quality standards, including those outlined in 42 CFR 438 Subpart D, which establish the framework to drive QI. Ensuring MCE adherence to these standards is key to providing high-quality, clinically-appropriate care that is accessible to all Medicaid recipients.

The following access standards outlined in this section are designed to ensure that MCE networks:

- are of adequate size;
- meet geographic access requirements;
- include sufficient numbers of primary care providers (PCPs) and medical specialists;
- maintain adequate and timely coverage of services not available in network;
- require out-of-network providers coordinate with the MCE with respect to payment;
- ensure that services included in the contract are available seven days a week and 24 hours each day; and
- safeguard enrollee privacy and ensure that it is protected when coordinating care.

MLTC stipulates through its contract with the MCE that their network must conform to the requirements outlined below, with respect to policies that must be in place and to access and availability standards to which its providers should adhere.

Provider Network Adequacy Requirements

- The network must be supported by written contracts between the MCE and its providers.
- The MCE must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.
- There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.
- The MCO must have available non-emergent after-hours physician or primary care services within its network.
- Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in **Appendix F: MCO Access Standards** and **Appendix G: DBPM Access Standards** (corresponding with MCO contract Attachment 39 – Revised Access standards, and DBPM contract Attachment 4 – Dental Access Standards).
- The MCE must take corrective action if it, or its providers, fail to comply with the timely access requirements.
- The MCO must make a good faith effort to contract with urgent care centers in the state to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.
- In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCE must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCE, or in which the MCE agrees that it will not contract with another provider. The MCE must not advertise or otherwise hold itself out as having an

exclusive relationship with any provider.

- In all its contracts with health care professionals, the MCE must comply with the requirements specified in 42 CFR 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.
- MLTC has specific cultural competency access standards, which include client access to more than one PCP that is multi-lingual and culturally diverse. The MCEs must have a searchable database that includes network providers and facilities with information regarding race/ethnicity and languages. The 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.
- The MCE must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR 438.206(c)(2).
- The MCE must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.
- The MCE must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.
- The MCE must consider availability of triage lines or screening systems, as well as the use of telemedicine, e-visits and/or other evolving and innovative technical solutions.
- The MCE must ensure adequate and timely coverage of services not available in network.
- Out-of-network providers should coordinate with the MCE with respect to payment.
- The MCE must protect enrollee privacy when coordinating care.

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

- its anticipated Medicaid enrollment;
- the expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCE;
- the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
- the numbers of network providers who are not accepting new Medicaid patients;
- the geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities; and
- members with SHCNs, including individuals with disabilities. The MCE should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.

Primary Care Provider Access

The MCO must provide an adequate network of PCPs to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP and must have the opportunity to seek a second opinion from a qualified health care professional. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (ob/gyn). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license. The MCO must also share with other MCOs that serve members with SHCNs the results of identification and assessment to prevent duplication of services.

Specialist Access

The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric PCPs; high-volume specialties (cardiology, neurology, hematology/oncology, ob/gyn, and orthopedic physicians); behavioral health; and urgent care centers, federally qualified health centers (FQHCs), rural health centers (RHCs), and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.

The DBPM must establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum, the DBPM is in compliance with access and availability standards, and has signed a contract with providers of the following specialty types who accept new members and are available on at least a referral basis; endodontists, oral surgeons, orthodontists, pedodontists, periodontists, and prosthodontists.

The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist. The DBPM must meet standards for timely access to all specialists. In accordance with 42 CFR §438.208(c)(4) for members determined to need a course of treatment, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

Behavioral Health Provider Access

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

- co-occurring mental health and substance use disorders;
- co-occurring mental health and substance use disorders and developmental disabilities;
- serious and persistent mental illness;
- severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities);
- sex-offending behaviors;
- eating disorders; and
- co-occurring serious mental illness (SMI) and common chronic physical illnesses.

The MCO must contract with providers who demonstrate a commitment to the behavioral health principles of care, including principles of rehabilitation and recovery from mental illness and SUD; a focus on recovery-oriented, trauma-informed services and trauma-specific treatment (e.g., trauma-focused cognitive behavioral therapy); consumer and family involvement in program management and oversight; a family-driven and strengths-based approach to working with children and their families; cultural and linguistic competency; and training for staff about these principles. In addition, the MCO must collaborate with the NE DHHS Division of Behavioral Health (DBH) and state behavioral health regions in establishing its network.

Appointment Availability Standards

Nebraska's appointment availability standards are included in **Appendix F: MCO Access Standards** and **Appendix G: DBPM Access Standards of this Quality Strategy**. MLTC will monitor MCE compliance with these standards through regular reporting per **Appendix D: MCO Reporting Requirements** and **Appendix E: DBPM Reporting Requirements**. Additional standards are as follows:

- Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with

appointment availability standards.

- Follow-up to emergency room (ER) visits must be available in accordance with the attending provider's discharge instructions.
- Direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number at any time. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.
- The DBPM must have a toll-free line with an automated system, available 24-hours a day, and seven (7) days a week, including all federal and state holidays. This automated system must include the capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.
- The MCE is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.
- The MCE must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCEs.
- The MCE must monitor the practice of placing members who seek any covered services on waiting lists. If the MCE determines that a network provider has established a waiting list and the service is available through another network provider, the MCE must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.

With regard to non-emergency medical transportation, the MCO must ensure that members arrive promptly for appointments, without excessive wait-time for pick-ups or drop-offs prior to appointments. The pick-up and wait times should align with the following requirements:

- The wait time for a pick-up to a scheduled appointment should not exceed 60 minutes prior to the scheduled appointment time.
- The member should not wait more than 30 minutes from drop off time to their scheduled appointment time;
- The wait time for a scheduled return trip, after an appointment, should not exceed sixty 60 minutes.
- Members may be picked up on a "will call" basis, which should also not exceed 60 minutes wait time after the NEMT provider is contacted for the return trip.
- For multiple passenger trips, which are only allowed for commercial providers when the first member approves multi-loading, members should not remain in the vehicle for more than 45 minutes longer than the average travel time for transport, for an individual client using that mode, from the point of pick-up to the destination.
- Exceptions to service delivery times specified herein may be made for trips with pick-up or destinations outside the client's local area, or verified scheduled consecutive trips.
- Exceptions may also be made due to unusual situations such as exceptional distances in rural areas or other situations out of the control of the NEMT provider.
- During periods of inclement weather conditions, the MCO should have written procedures in place that at a minimum includes notifying the members of the delay, the alternative schedule, and of any alternate pick-up arrangements.

Geographic Access Standards

The following guidelines describe the specific geographic standards required of the MCE, including travel time and distance requirements and network adequacy:

- The MCE must comply with maximum travel times and/or distance requirements per **Appendix F: MCO Access Standards** and **Appendix G: DBPM Access Standards**. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.
- The MCE must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that are taken to address those gaps. When a gap is identified, the MCE must document its efforts to engage any

available providers (e.g., three good-faith attempts) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.

- The MCE must establish a program of assertive outreach to rural areas where covered services may be less available than in urban areas, and must include any gaps in its availability plan.
- The MCE must monitor utilization across the state to ensure access and availability, consistent with the requirements of the contract and the needs of its members.

Utilization Management Standards

- The MCE's UM activities must include the evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them. The MCE's UM program must also focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services.
- The MCE's UM program must comply with federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 456.
- The MCO must require inpatient hospital providers to comply with federal requirements regarding UM plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 CFR 44, 455 and 456.
- The MCE must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member, as described in 42 CFR 438.210(e).
- The MCE must actively monitor federal and state Medicaid regulations for updates and changes and must monitor all UM activities for compliance with federal and state Medicaid regulations.

Clinical Practice Guidelines

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

- The MCE must develop practice guidelines, in accordance with 42 CFR 438.236(b), that:
  - are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
  - consider the needs of the MCE's members, including children with serious emotional disorders and adults with serious and persistent mental illness;
  - are adopted in consultation with participating health care professionals;
  - comply with state and federal requirements;
  - are approved in advance by the Clinical Advisory Committee (CAC) and MLTC;
  - are reviewed and updated a minimum of annually, as appropriate;
  - are disseminated by the MCE to all affected providers and, upon request, to enrollees and potential enrollees;
  - are posted to the MCE's website; and
  - provide a basis for consistent decisions for UM, member education, service coverage, and any other areas to which the guidelines apply.
- The MCE must provide affected network providers with technical assistance and other resources to implement the practice guidelines.
- The MCO must coordinate the development of clinical practice guidelines with other MLTC MCOs to avoid providers receiving conflicting guidelines from different MCOs.
- The MCE must monitor the application of practice guidelines annually through peer review processes and collection of PMs for review by the MCE's QAPI Committee.
- Using information acquired through its QM and UM activities, the MCE must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into CM and utilization review activities.

Structure and Operations Standards

Provider Selection, Credentialing, and Re-credentialing

Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment. The MCEs may not employ or contract with providers excluded from federal health care programs. The state standards relating to this requirement are specified as follows:

- The MCE is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.
- The MCE must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCE must:
  - review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or
  - deny the application and ensure that the provider is not used by the MCE. A provider whose application is denied must receive written notification of the decision, with a description of their appeal rights.
- A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of their appeal rights.
- If the MCE delegates credentialing to a subcontractor, the MCE must obtain MLTC approval of (a) the subcontractor and (b) the credentialing process, including components delegated to the MCE's subcontractor. The MCE must require that all licensed medical professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC retains final approval of the credentialing subcontractor and process.
- The MCE must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCE must also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
- The MCE must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.
- The MCE must re-credential each provider a minimum of every 3 years, taking into consideration various forms of data, including, but not limited to, grievances, results of quality reviews, results of member satisfaction surveys, and UM information.
- The MCE must communicate with MLTC, NE DHHS DBH, and NE DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.

Confidentiality

All materials and information provided by MLTC or acquired by the MCEs on behalf of MLTC are regarded as confidential information. MLTC requires MCEs to ensure that personal health information is protected and disclosed only as permitted or required. The MCE must have written policies and procedures to maintain the confidentiality of all medical records in compliance with applicable law, establishing and implementing procedures to ensure that confidentiality requirements in 45 CFR Parts 160 and 164 are met for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law. The MCEs must report any breach of confidentiality to MLTC immediately and take immediate corrective action. It is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a.

New members are made aware of the regulations that protect their health information during welcome calls made by the MCE within 15 days of receiving their welcome packet. Providers are made aware of confidentiality provisions via the provider handbook, which is reviewed and approved by MLTC prior to being published by the MCE.

Health Information Systems

The MCEs are required to maintain and ensure the accuracy of their HIS in support of MLTC's Quality Strategy. MLTC specifies required claim system edits and requires the MCEs to be accredited by the NCQA to ensure that the MCEs are submitting valid data**.**

- The MCE must maintain a HIS that can collect, analyze, integrate and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
- The MCE must collect data on enrollee and provider characteristics and on services furnished to enrollee, and ensure these data are accurate and complete.
- The MCE must comply with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state.
- The MCE must make all collected data available to the state and, upon request, to CMS.

Enrollment and Disenrollment

The state of Nebraska is responsible for all enrollment activities, including disenrollment and member outreach and education, through a contractual arrangement with its enrollment broker.

Enrollment and Disenrollment – MCOs

NE DHHS administers and manages eligibility for Medicaid and economic assistance programs through ACCESSNebraska. Individuals can apply for Medicaid benefits on the ACCESSNebraska website (ACCESSNebraska.ne.gov), over the telephone with dedicated Medicaid eligibility customer service staff, or by visiting designated local offices. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of an MCO. MLTC's enrollment broker is also responsible for providing impartial counseling to assist members in this selection process. The enrollment broker auto-assigns enrollees who do not select a specific MCO.

The MCO must accept all eligible individuals who select the MCO or are assigned to it. The MCOs cannot discriminate against MCO members based on their health history or status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, ethnicity, or language needs. This applies to enrollment, re-enrollment, or disenrollment from the MCO.

MLTC's enrollment broker is required to send to the MCO a daily electronic transmission file that contains the names, addresses, and telephone numbers of all members newly assigned to the MCO, with an indicator for members who were auto-assigned. The MCO must use this file to identify new members, initiate communication with new members via welcome packet mailings and calls, and assign members to a PCP, if the member has not already chosen one. At initial enrollment, if an enrollee selects an MCO and a PCP, the assignment of the PCP is included on the enrollment file sent to the MCO. If no PCP selection is indicated on the enrollment file, the MCO must contact the member to assist with selecting a PCP within 10 business days of receipt of the enrollment file, and assign a PCP within one month of the enrollment date a PCP is not chosen.

MCOs may only request disenrollment of members if there is sufficient documentation or evidence of fraud, forgery or unauthorized use/abuse of services by the member, or if the member's abusive, disruptive or uncooperative behavior impairs the MCO's ability to serve the member or other members. The MCOs cannot request disenrollment because of a member's diagnosis; adverse change in health status; service utilization; diminished medical capacity; pre-existing medical condition; refusal of care; and uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the MCO's ability to furnish services to the member or other MCO members. The MCOs cannot request disenrollment for members who file a grievance or appeal or exercise their right to change a PCP for cause, as per 42 CFR 438.56(b)(2).

A member may initiate a request for disenrollment from a MCO if the MCO does not cover needed services because of moral or religious objections; because the member requires related services to be delivered at the same time as determined by the member's PCP or other provider that are not available with the MCO; and due to lack of access to covered benefits and services, quality care or appropriately experienced providers. Members also have the opportunity

to request a different MCO during the annual enrollment period, upon re-enrollment if the member missed the enrollment period, or if MLTC imposes intermediate sanctions on the MCO, as per 42 CFR 438.700.

MLTC's enrollment broker communicates the Medicaid eligible individuals that are enrolled, re-enrolled, or disenrolled from the MCO each month. As stipulated in 42 CFR 438.62(a), MLTC's enrollment broker must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO whose contract is terminated, and for any Medicaid enrollee who is disenrolled for any reason other than ineligibility for Medicaid.

Enrollment and Disenrollment – DBPM

MLTC's enrollment broker provides Nebraska Medicaid recipient information to the DBPM via a daily 834 electronic file transfer, hereafter referred to as the "Member File." The DBPM utilizes the Member File to identify all individuals eligible for enrollment, based on predetermined eligibility criteria. The DBPM's responsibilities subsequent to eligibility determination include, but are not limited to, the following:

- being available by telephone to provide assistance to DBP potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the DBPM, the role of the dental home, the responsibilities of the DBPM member, the member's right to file grievances and appeals, and the member's right to choose any dental home within the DBPM, subject to the capacity of the provider;
- educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBPM; and
- identifying any barriers to access to care for members, such as the necessity for multi-lingual interpreter services and special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

Disenrollment is any action taken by MLTC or its designee to remove a member from the DBPM following the receipt and approval of a written request for disenrollment or a determination made by MLTC or its designee that the member is no longer eligible for Medicaid or the DBPM.

MLTC notifies the DBPM of the member's disenrollment due to reasons such as the following:

- loss of Medicaid eligibility or loss of DBPM enrollment eligibility,
- death of a member,
- member's intentional submission of fraudulent information,
- member becoming an inmate in a public institution,
- member moving out-of-state, and
- to implement the decision of a hearing officer in an appeal proceeding by the member against the DBPM or as ordered by a court of law.

Cooperation with Other Entities and Programs

The MCE must collaborate with other entities and programs when serving members and identifying and responding to members' health needs. It must address and attempt to resolve any coordination of care issues with other MCEs and other state agencies and their contractors, tribes, and other community providers as expeditiously as possible. The MCE must also collaborate with these entities and programs and its network providers regarding planning initiatives and system transformation.

Cooperation with Other Entities and Programs – MCOs

By requiring MCOs to collaborate with other entities and programs that serve the needs of MMC members, Heritage Health can more effectively promote quality of care, utilizing the resources of these entities to ensure members served by multiple programs receive the care and support necessary. The MCO must develop processes and procedures and designate points of contact for collaboration with other entities that serve members, including:

- programs funded by the DBH;
- programs funded by the Division of Children and Family Services (DCFS) that support the safety, permanency, and well-being of children in the care and custody of the state;
- the Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities;

- the Nebraska Department of Education Early Development Network;
- community agencies including, but not limited to, the Area Agencies on Aging and League of Human Dignity Waiver Offices;
- the Office of Probation; and
- other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

Specific examples of the types of collaboration that MLTC requires that the MCO engage include:

- an understanding of health care and social service programs and initiatives offered by MLTC and other state agencies; the MCOs should leverage those programs when appropriate for members receiving medium and intensive CM; leveraging of existing programs may take the form of subcontracting or highly collaborative partnering, for example, and is intended to take advantage of existing resources and infrastructures to reduce or eliminate duplication of effort; highly collaborative partnering must include, but is not limited to, crisis response services in coordination with behavioral health system entities;
- responsibility for ensuring coordination between its providers and the Women, Infants, and Children (WIC) program; coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program;
- developing transition plans for persons discharging to the community from state psychiatric hospitals;
- collaboration and coordination with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports;
- developing processes and procedures for collaboration with the DCFS for children who are in foster care placement; and
- collaboration between the MCO's case manager and the child's Children and Family Services specialist and identifying and responding to a child's health care needs including behavioral health; policies and procedures must include the following provisions:
    - a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice,
    - how health needs identified through screenings will be monitored and treated,
    - how medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record,
    - steps to ensure continuity of health care services, and
    - the oversight of prescription medications.

Cooperation with Other Entities and Programs – DBPM

The DBPM must develop processes and procedures and designate points of contact for collaboration with other entities and programs that serve members including, but not limited to:

- Nebraska Office of Oral Health and Dentistry programs including the Oral Health Access for Young Children program;
- Together For Kids and Families – Medical/Dental Home Work Group;
- DBH funded programs;
- Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the state;
- Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities;
- The Nebraska Department of Education Early Development Network;
- community agencies including, but not limited to, the Area Agencies on Aging and League of Human Dignity Waiver Offices;
- The Office of Probation; and
- other MLTC programs, initiatives, and contractors related to dental care and health care coordination, including Heritage Health MCOs.

Grievance System Standards

NE DHHS, at its discretion, conducts random state reviews of notice of action delegation to ensure that enrollees are notified in a timely manner. Requirements include that MCEs must have a grievance system and policy in operation that:

- provides for the right for an enrollee to file a grievance;
- notifies enrollees of any adverse action taken against them and stipulates timeframes for the notification and response to the notification;
- provides for the right of enrollees to file an appeal;
- maintains policies for standard and expedited service authorization service denials;
- details the appeals process, including:
  - timeframes for filing an appeal and furnishing a response, and
  - a process for filing an expedited appeal;
- details continuation of benefits policy and how enrollees can request to have their benefits continued;
- provides for access to state fair hearings and provisions for reversed appeals;
- includes a system or process for recordkeeping that is auditable;
- makes the grievance and appeal policies and information known and accessible to their members and subcontractors;
- reports complaints, grievance and appeal regularly to the NE DHHS; and
- holds subcontractors to the same standards to which MCEs are held and monitors their performance.

Specific state requirements related to the MCE grievance systems, policies and procedures are presented below:

- The MCE must have a grievance system for members that meet all federal and state regulatory requirements, including a grievance process, an appeal process, and access to the state's fair hearing system. The MCE must distinguish between a grievance, grievance system, and grievance process, as defined below:
  - A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of an adverse benefit determination.
  - The grievance system includes a grievance process, an appeal process, and access to the state's fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process.
  - A grievance process is the procedure for addressing members' grievances.
- The MCE must:
  - give members reasonable assistance in completing forms and other procedural steps, including, but not limited to, providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability;
  - acknowledge receipt of each grievance and appeal in writing to the member within 10 calendar days of receipt;
  - 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 or appeal 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 or appeal requires expedited resolution, and
    - the grievance or appeal involves clinical issues;
  - take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision; and
  - provide access to MLTC and/or its designee for any information related to grievances or appeals filed by its members. MLTC will monitor enrollment and termination practices to ensure proper implementation of the MCE's grievance procedures, in compliance with 42 CFR Subpart F.

Complaint and Grievance Processes

- A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.
- A member may file a grievance with the MCE or the state at any time.

- The MCE must address each grievance and provide notice, as expeditiously as the member's health condition requires, within state-established timeframes and not to exceed 90 calendar days from the day on which the MCE receives the grievance.
- MLTC will establish the method the MCE must use to notify a member of the disposition of a grievance.
- Service authorization:
  - The MCE must ensure services are sufficient in amount, duration and scope that is no less than those furnished to FFS Medicaid beneficiaries and are expected to achieve the purpose for which the service was furnished.
  - The MCE and their subcontractors must have written policies and procedures for authorization of services.
  - The MCE must have mechanisms to ensure consistent application of review criteria for authorization decisions.
- The MCE must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.
- The MCE must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

Notice of Adverse Action

The MCE must notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404. The MCE must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:

- the action the MCE or its subcontractor has taken or intends to take;
- the reason(s) for the action;
- the member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits; such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
- the member's or the provider's right to file an appeal;
- the member's right to request a state fair hearing;
- procedures for exercising a member's rights to appeal or grieve a decision;
- circumstances under which expedited resolution is available and how to request it;
- the member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and
- the notice must be in writing and must meet the language and format requirements described in Section IV.F Member Services and Education of the Heritage Health Contract.

Timeframes for Notice of Action

- The MCE must provide notice to the member a minimum of 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
- The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified.
- The MCE must give notice by the date of the action under the following circumstances:
  - the death of a member;
  - a signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services;
  - the member's admission to an institution where he or she is ineligible for further services;
  - the member's address is unknown and mail directed to him/her has no forwarding address;
  - the member has been accepted for Medicaid services by another state;
  - the member's physician prescribes the change in the level of medical care;
  - an adverse determination is made with regard to the preadmission screening requirements for nursing facility (NF) admissions on or after January 1989; and
  - the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the NF for 30 calendar days (applies only to

adverse actions for NF transfers).

- The MCE must provide notice on the date of action when the action is a denial of payment.

Standard Service Authorization Denial

NE DHHS requires that the MCEs cannot make any arbitrary denial or reduction in service solely because of diagnosis, illness or condition. Compensation to individuals or entities that conduct UM activities requires that they do not provide incentives to deny, limit, or discontinue medically necessary services. The MCE 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. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCE justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCE 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 MCE must issue and carry out its determination as expeditiously as the member's health condition requires and in any event no later than the date the extension expires.

Expedited Service Authorization Denial

For cases in which a provider indicates or the MCE determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCE may extend the time period by up to 14 calendar days if the member requests an extension or if the MCE justifies a need for additional information and the reason(s) why the extension is in the member's interest.

Untimely Service Authorization Decisions

The MCE must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.

Appeal Processes

MLTC is committed to a comprehensive appeals process that allows redress for MMC members and providers seeking eligibility for program coverage of prescribed services. It provides for a multi-layered appeals system with prescribed timeframes and reporting requirements. Provision is made for expedited appeals and a state fair hearing. Specific elements of the appeals process are detailed below:

- A member may file an MCE-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.
- Following receipt of a notification of an adverse benefit determination by the MCE, the member has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCE.
- The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.
- The MCE must:
  - ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution;
  - ensure that there is only one level of appeal for members;
  - provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
  - provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination; and
  - consider the member, representative, or estate representative of a deceased member as parties to the appeal.
- The MCE must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the MCE receives the appeal. The MCE may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCE shows that there is need for additional information

and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCE must:

- make reasonable efforts to give the member prompt verbal notice of the delay;
- within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision;
- resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires; and
- provide written notice of disposition, which must include:
  - the results and date of the appeal resolution; and
  - for decisions not wholly in the member's favor:
    i. the right to request a state fair hearing,
    ii. how to request a state fair hearing,
    iii. the right to continue to receive benefits pending a hearing, and
    iv. how to request the continuation of benefits.

- If the MCE action is upheld in a hearing, the member may be liable for the cost of any continued benefit received while the appeal was pending.

Expedited Appeals Process

- The MCE must establish and maintain an expedited review process for appeals that the MCE determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.
- The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.
- The MCE 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.
- The MCE must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than 72 hours after the MCE receives the appeal. The MCE may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCE shows that there is need for additional information and the reason(s) why the delay is in the member's interest.
- For any extension not requested by the member, the MCE must give the member written notice of the reason for the delay.
- In addition to written notice, the MCE must also make reasonable efforts to provide verbal notice of resolution.
- The MCE must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.
- If the MCE denies a request for expedited resolution of an appeal, it must:
  - transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCE receives the appeal with a possible extension of 14 calendar days; and
  - make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.

Continuation of Benefits

Continuation of Benefits – MCO

- The MCO must continue a member's benefits if all of the following occur:
  - the member files the request for an appeal timely;
  - the appeal involves the termination, suspension, or reduction of previously authorized services;
  - the services were ordered by an authorized provider;
  - the period covered by the original authorization has not expired; and
  - the member timely files for continuation of benefits, timely files means on or before the later of the following:
    - within 10 calendar days of the MCO sending the notice of adverse benefit determination, and

        - the intended effective date of the MCO's proposed adverse benefit determination.
- If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
    - the member withdraws the appeal or request for state fair hearing;
    - the member fails to request a state fair and continuation of benefits within 10 calendar days after the MCO send the notice of an adverse resolution to the member's appeal;
    - the state fair hearing office issues a hearing decision adverse to the member; or
    - the authorization expires or authorization service limits are met.
- The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action to the extent that the services were furnished solely because of the requirements of this section.

Continuation of Benefits – DBPM

- The DBPM must continue a member's benefits if any one of the following apply:
    - The appeal is filed timely, meaning on or before the later of the following:
        - ten (10) calendar days after the DBPM mailing the notice of action; or
        - the intended effective date of the DBPM's proposed action.
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
    - The services were ordered by an authorized provider.
    - The authorization period has not expired.
    - The member requests an extension of benefits.
- If the DBPM continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
    - The member withdraws the appeal.
    - The member does not request an appeal within 10 calendar days from when the DBPM mails an adverse DBPM decision.
    - A state fair hearing decision adverse to the member is made.
    - The authorization expires or authorization service limits are met.
- The DBPM may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the DBPM action.

Access to State Fair Hearings

- A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or their representative may request a state fair hearing only after receiving notice that the MCE is upholding the adverse benefit determination.
- If the MCE takes action and the member requests a state fair hearing, the state must grant the member a state fair hearing. The right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the MCE.
- The member or the member's representative (if any) may request a state fair hearing within a timeframe that is no later than 120 calendar days from the date of the MCE's notice of resolution.
- The parties to the state fair hearing include the MCE, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.
- The state must ensure that any member dissatisfied with a determination denying a member's request to transfer plans/disenroll is given access to a state fair hearing.

Reversed Appeals

If the MCE or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than 72 hours from the date the MCE receives notice reversing the determination. The MCE must pay for disputed services if the MCE or state fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

Grievance and Appeal Recordkeeping Requirements

- The MCE must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information:
  - a general description of the reason for the appeal or grievance,
  - the date the grievance or appeal was received,
  - the date of each review or, if applicable, review meeting,
  - resolution at each level of the appeal or grievance process, as applicable,
  - the date of resolution at each level of the appeal or grievance process, as applicable, and
  - the name of the covered person by or for whom the appeal or grievance was filed.
- The MCE is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.

Information to Providers and Subcontractors

The MCE must provide the following grievance, appeal, and state fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract:

- the member's right to a state fair hearing, how to obtain a hearing and representation rules at a hearing;
- the member's right to file grievances and appeals and the requirements and timeframes for filing them;
- the availability of assistance in filing grievances or appeals, and participating in state fair hearings;
- the toll-free number(s) to use to file verbal grievances and appeals;
- the member's right to request continuation of benefits during an appeal or state fair hearing filing and, if the MCE's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending; and
- any state-determined provider appeal rights to challenge the failure of the organization to cover a service.

Reporting of Complaints, Grievances, and Appeals

The MCE is required to submit grievance and appeals data quarterly. This information is used by MLTC to measure the MCE's performance.

Subcontracting Standards

The MCE must not execute a subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. The MCE must not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

As required by 42 CFR 438.230, the MCE is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

- The MCE must evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- The MCE must ensure that the prospective subcontractor is financially stable, according to the MCE's standards.
- The MCE must have a written contract between the MCE and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The MCE must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.
- If necessary, the MCE must identify deficiencies or areas for improvement, and take corrective action.
- The MCE must submit all subcontracts for the provision of any services to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation. MLTC must have the right to review and approve or disapprove all subcontracts entered into for the provision of any services.

Care Management Standards

The MCO's CM program must focus on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators. The MCO must work with its providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem. Principles that guide this care integration include:

- The system of care must be accessible and comprehensive, and fully integrate an array of prevention and treatment services for all age groups. It must be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous QI.
- Mental illness and SUD are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings.
- Many people suffer from both mental illness and SUD. As care is provided, both illnesses must be understood, identified, and treated as primary conditions.
- Relevant clinical information must be accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

The MCO must assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition. The MCO must incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. CM must engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate.

The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services. The MCO's CM program must address the social determinants of health and how they may affect members' health and wellness. This requirement includes:

- ensuring that all covered services, including mental health or SUD treatment services, appropriate to a member's level of need, are available when and where the member needs them;
- ensuring that all CM staff are familiar with available community resources and will refer members to these resources, such as, but not limited to, housing assistance programs and shelters, food banks/pantries, educational opportunities, and organizations which can assist with and address physical and/or sexual abuse;
- developing, subscribing to, or acquiring a tool accessible to its CM staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO must make access to this information available to MLTC staff on request.

A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained about how social determinates affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, and violence. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

The MCO is required to provide CM separate from, but integrated with, UM and QI activities. The major components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.

A minimum of 60 calendar days prior to the contract start date, the MCO must provide to MLTC for review and approval a CM program description, policies and procedures, a description of services available at each CM level, member outreach procedures, and flow diagrams.

The MCOs must submit policies and procedures specific to CM for individuals who are dually eligible, have adult-onset disabilities, developmental disabilities and/or otherwise receive institutional or community-based long-term supports and services that address the unique needs of these populations. In addition, the MCO must annually review, and

update as necessary, with the input, review, and approval of the CAC, the CM policies and procedures. Once they are approved by the CAC, any proposed changes must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to intended implementation. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.

Improvement and Interventions

Medicaid Committees

The Behavioral Health Integration Advisory Committee, the Administrative Simplification Committee and the Administrative Simplification Subcommittee were developed by MLTC in 2016. These committees shared similar member participation and had goals which focused on the transition into the Heritage Health Program. Each of these committees met regularly and had key roles in Nebraska Medicaid's successful transition in to the expanded MMC program.

As these committees addressed and managed issues through the transition agenda topics diminished, and so at the close of 2018 MLTC decided the committees would merge into the Heritage Health Stakeholder Forum, maintaining an overall mission to provide a comprehensive forum to explore process improvements, provide feedback, and assess innovative ideas to streamline the provider experience and improve health outcomes for Heritage Health members. Through 2019 this merged committee met every other month. Membership in the committees also merged, and continued to include broad representation from provider associations, MCEs, patient and community advocates, MLTC leadership, various state program administrators, Heritage Health members or family members and systems experts. Due to low attendance and content which was duplicative from other public venues, beginning in 2020 the Heritage Health Stakeholder Forum attendees are invited to attend the Medical Assistance Advisory Committee (MAAC).

The Medical Assistance Advisory Committee

42 CFR 431.12 prescribes that states establish a committee of external stakeholders to advise the Medicaid agency about health and medical care services. Nebraska's committee which was developed according to this regulation is the MAAC. Along with the federal regulations, the MAAC is included in the Nebraska State Plan Amendment, state regulation 471 NAC 1-004.01, and by-laws adopted by the committee in March 2017. Also, Article I Section II of the by-laws state that the committee "shall have the opportunity for participation in policy development and program administration".

Members of the MAAC are appointed by the Medicaid Director. Membership is to include representation of board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including Medicaid clients and consumer organizations; all federally-recognized tribes in Nebraska; all Medicaid managed care plans contracted with the State of Nebraska; and the Director of the Division of Public Health in the Department of Health and Human Services.

During the quarterly MAAC meeting, attendees are updated on the Medicaid program by the Division and each MCE. Attendees are able to leave public comments for the Division to respond to and have access to the executive leadership of each MCE. In 2020 MLTC is expecting attendance at the MAAC to expand due to the invitations extended to members and attendees of the Heritage Health Stakeholder Forum. Due to this change it is the intention of MLTC that the format of the meeting agenda will be adjusted to account for the reception of additional interactions with MAAC attendees in order for this committee to have an expanded impact on the Medicaid program.

Heritage Health Quality Management Committee

The Quality Management Committee was established to advise MLTC on clinical and operational quality initiatives and provide oversight of the Heritage Health Quality Management Program.

Functions of the Heritage Health Quality Committee include reviewing and recommending updates to MLTC's Quality Strategy Plan, recommending topics for PIPs, reviewing results of the MCO's active PIP topics, and recommending actions which intend to improve areas such as quality of and access to care, utilization, and member or client satisfaction.

The Quality Management Committee includes representation from medical experts, providers, patient and community advocates, managed care contractors, state program administrators, as well as system and policy experts. Members, excluding those representing the state or MCOs, serve two-year terms. This cross-agency collaboration facilitates effective quality improvement initiatives to improve health care quality, service integration and health outcomes for vulnerable subpopulations that are served by multiple programs across the state agencies such as the Division of

Behavioral Health, DCFS, Department of Education and Department of Probation.

Healthcare Oversight Team

Healthcare Oversight Team was organized by the DCFS as part of a Healthcare and Coordination Plan to share information and provide recommendations for the ongoing oversight and coordination of health care services for children who are in the care and custody of DCFS. Team members represent entities related to children served by DCFS and include MLTC, the Division of Developmental Disabilities, the Division of Public Health, DCFS and the DBH, as well as other stakeholders such as providers and advocates. The goals of the Healthcare Oversight Team are aligned with Quality Strategy goals and include accessible health care services and coordinated health care initiatives across all NE DHHS divisions and community partners. The Healthcare Oversight Team makes recommendations for program enhancements based on review and identification of gaps in existing programs, policies and initiatives. The team focuses on collaboration, coordination, and accessibility of medical and mental health services for children. MLTC has a key role on the team, since Medicaid-eligible state ward children are enrolled in MMC, and ensures the coordination, continuity, and access of medical care for children. The Heritage Health delivery system facilitates access to a PCP, coordination of care through behavioral health and physical health integration, an emphasis on preventive care and the appropriate utilization of services. By participating in the Healthcare Oversight Team, MLTC participates in the development of a comprehensive plan and strategies to address the goals of the Quality Strategy, including improved health care outcomes, enhanced integration of services and quality of care, and emphasizing person-centered care.

Value-Based Purchasing Initiatives

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

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

The state requires MCOs to enter into value-based contracts with a growing portion of its contracted providers over the five-year contract period, and with at least 50% of its providers by the fifth year of the contract. It is anticipated that this movement toward VBP will facilitate progress toward the Quality Strategy goals of enhanced quality of care, improved outcomes, and reduced costly and avoidable care.

Health Information Technology

Medicaid Management Information System Replacement

NE DHHS is in the process of replacing the current Medicaid Management Information System (MMIS) which is outdated. The current priority for the MMIS replacement project is the data management and analytics (DMA) solution, which is under development. In February 2018, MLTC began work to implement a DMA solution that includes a data warehouse, decision support, program reporting, federal and ad-hoc reporting, management and administrative reporting (MAR), surveillance and utilization review (SUR), and fraud and abuse detection (FAD) case management. The DMA project is anticipated to launch in April 2020 and will help the Division work as a data-driven organization.

Eligibility and Enrollment System Development

NE DHHS administers and manages the eligibility for Medicaid and economic assistance programs through ACCESSNebraska. Currently, individuals can apply for Medicaid online at http://www.ACCESSNebraska.ne.gov, over the telephone, or by visiting a designated local office. The system that NE DHHS uses to enroll member into Nebraska MMC and the economic assistance program is over 20 years old and does not meet federal requirements for enhanced funding. Therefore, NE DHHS is in the process of developing a new Eligibility and Enrollment System (EES). The enhanced EES will allow for improved reporting that is required by CMS and better data eligibility and enrollment data exchange between NE DHHS and or enrollment broker and the MCE.

IPRO Encounter Validation Audit

At the request of MLTC, IPRO will gather claims/encounter data from the NE DHHS data warehouse, and data from the

MCEs, in order to conduct a comparison of claims reported and thus assess data completeness. This audit ensures that the MCEs are submitting complete and accurate encounter data so they can be used by the state to set capitation rates, monitor/measure MCE performance, measure access to health care, and assess how well the Medicaid program meets the needs of enrollees. Quality encounter data assist NE DHHS in program management, analysis, quality initiatives and monitoring activities. Further, these data are a source for applying data mining techniques, which can identify utilization trends, patterns of care and potential waste. These results are shared with the MCEs, to inform them of any quality improvement opportunities that may exist. For instance, based on previous encounter data studies, it has been recommended that the following actions be taken:

- Add a check for faulty claims where member's date of birth exceeds the date of service and conduct checks to see where adjudication dates exceed the actual claim submission to the state.
- Investigate the discrepancy records to verify these are not captured in the current NE DHHS data warehouse. For claims listed as "successfully submitted," NE DHHS should verify if these claims were captured. NE DHHS could explore if there are discrepancies in the adjudication dates listed on the MCE claims versus what is listed in the NE DHHS data.
- Assess if member information such as names, Medicaid IDs, and dates of birth on Medicaid registries are up to date and if MCEs are cross checking collected information on members against federal or state controlled databases. NE DHHS data had several records that did not match on member date of birth for a few individuals, and member names varied slightly.
- Investigate the differences in provider names associated with national provider identifiers (NPIs) between the MCE-submitted data and NE DHHS data. When EQROs or state entities conduct validations on MMIS encounter data using HEDIS measures, having accurate NPI and provider names can assist in validating HEDIS measures across MCEs for medical chart reviews.

Delivery System Reforms

Populations Included in Heritage Health

Since 2017, Heritage Health has included groups of enrollees who had previously been excluded from participation from the state's physical health managed care program, but who have received their behavioral health services through the state's behavioral health managed care contractor. Individuals now have their physical, behavioral and pharmacy health services coordinated by their Heritage Health plan.

MLTC also provides assistance to disabled or blind individuals who cannot receive supplemental security income (SSI) due to a disability which is expected to last less than 12 months. The Aid to the Aged, Blind, or Disabled (AABD) payment program provides cash payment to persons who are blind or disabled based on Social Security rules. Further, MLTC's Refugee Resettlement Program (RRP) helps newly arrived refugees and other eligible populations establish a new life and self-sufficiency following their arrival in the United States. Medical and cash assistance is provided for up to eight months after arrival in the U.S., and health screening and initial vaccinations are provided within 90 days after arrival.

Heritage Health Adult Program

The HHA has a planned implementation date of October 1, 2020, pending CMS approval of MLTCs Section 1115 Heritage Health Adult Expansion Demonstration. In this program, eligibility will be extended to cover certain adult members whose incomes are 138% of the federal poverty level or below. This program will include a basic level of coverage (Basic Coverage) similar to coverage currently available on the commercial insurance market. Members can earn additional benefits (Prime Coverage) not traditionally covered by commercially available insurance, such as dental and vision services and over-the-counter medications. These benefits will be available if members complete certain wellness, ,personal responsibility, and community engagement activities.

In order to improve the patient experience of care under the Heritage Health Adult Program, Nebraska Medicaid encourages self-efficacy among members through requiring active participation in care and case management with their MCO in order to receive Prime Coverage. Additionally, members are incentivized to choose their own PCP and attend annual wellness check-ups with their doctor. Improving the provider experience of care involves personal responsibility of members, such as members attending their medical and dental appointments. Under the Heritage Health Adult Program, members will be assigned to Basic Coverage if they miss three or more appointments with no notice to the provider, if the member fails to inform the state of a change in status, or if the member voluntarily discontinues commercial health coverage.

HHA intends to empower individual life successes through positive community engagement. Beginning in the second year of the demonstration, to be eligible for the Prime benefits package, beneficiaries in the Medicaid expansion group must engage in approved community activities. These activities may include employment, pursuing educational opportunities, and volunteering with a public charity.

Retroactive Eligibility

Within the 1115 Heritage Health Adult Expansion Demonstration MLTC also seeks to waive the provisions of Section 1902(a)(34) of the Social Security Act and 42 CFR § 435.915 that otherwise require Medicaid eligibility to be effective up to three months prior to the month of application. This provision is operationally difficult for providers and the program to administer, delays the transition away from the outdated MMIS system, and persons covered by commercial insurance receive no such benefit. Pending approval from CMS, Medicaid eligibility will be retroactive only to the first day of the application month for most populations, including HHA Program members. Pregnant women; children age 0-18; beneficiaries dually-enrolled in Medicare and Medicaid and recipients who are residing in a NF will be excluded from this change.

Integration of Non-emergency Medical Transportation into Managed Care

Effective July 1, 2019, the NEMT service has been carved into the Heritage Health benefit package. This integration has allowed Heritage Health members to now access the NEMT benefit through his or her health plan directly. Placing NEMT into Heritage Health aligns with many of MLTC's long-term goals and strategies, such as maximizing the value of the managed care system and enhancing care coordination and management.

1115 SUD Demonstration Waiver

In the summer of 2019, MLTC received approval for a demonstration to maintain and enhance access to opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SUD.
This demonstration provides the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an institution for mental diseases (IMDs). It also supports state efforts to implement models of care focused on increasing support for individuals in the community and home, outside of institutions, and improve access to a continuum of SUD evidence-based services at varied levels of intensity.

Long-Term Services and Supports Redesign

Over the past several years, MLTC has engaged stakeholders in conversations regarding the delivery of long-term care (LTC). Those initial conversations resulted in a plan to implement managed LTC by partnering with MCOs via risk-based contracts. MLTC is taking the opportunity to open a broader dialogue with stakeholders regarding a comprehensive redesign and improvement of LTC services in Nebraska.

Conclusions and Opportunities

Advancing the Objectives of the Quadruple Aim

Nebraska's MMC program was implemented in 1995 and has steadily evolved to become an integrated health care model that covers members throughout the 93 counties in the state. As this program continues to evolve, further opportunities for integration have emerged, and have been addressed by MLTC, as demonstrated by the inclusion of non-emergency medical transportation into Heritage Health MCO benefits package in 2019. Opportunities have also emerged for improved data for reporting. As such, MLTC is in the process of replacing their MMIS to allow for decision support and improved reporting, scheduled for completion in April 2020. Additionally, a new EES system is in development, which would meet the standard for reporting to CMS and allow for improved data exchange between MCEs and their enrollment brokers.

MLTC remains focused on the Quadruple Aim in managing Medicaid business operations. The Quadruple Aim represents a rigorous and innovative approach to fulfilling the mission of Medicaid to furnish medical assistance to disadvantaged and vulnerable individuals through improving population health, enhancing the beneficiary and provider experience, and ensuring the long-term financial viability of the Medicaid program. Using the Quadruple Aim as a guide, the HHA program seeks to improve the health of the HHA population, improve HHA beneficiaries' patient self-management, improve the provider and beneficiary experience of care, and reduce inappropriate or unnecessary costs in the HHA population. Expansion of Medicaid coverage to an estimated 90,000 Nebraskans was approved by Nebraska voters in November 2019. The Department is planning to launch the HHA program October 1, 2020.

The state has also applied for waiver of the provisions of Section 1902(a)(34) of the Social Security Act and 42 CFR § 435.915 that would otherwise require Medicaid eligibility to be effective up to three months prior to the month of application. Under the waiver, retroactive eligibility would be limited to the first day of the month of application submission for certain Medicaid populations, including the HHA program members. The state has received approval for the 1115 SUD Demonstration Waiver, which would provide more coordinated and comprehensive care to Medicaid beneficiaries with SUD.

MLTC remains focused on and committed to integration, collaboration, and the Quadruple Aim to drive the Medicaid managed care program in the state. Medicaid business operations are closely monitored and assessed on a recurring basis via committee meetings, and by EQR to ensure Medicaid beneficiaries in Nebraska have adequate and timely access to quality care.

Appendix A: Neb. Rev. Stat. §71-831

71-831. Contracts and agreements; department; duties.

All contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the department on or after July 1, 2012, shall:

(1) Provide a definition and cap on administrative spending that (a) shall not exceed seven percent unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed ten percent;

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

(3) Provide for reinvestment of (a) any profits in excess of the contracted amount, (b) performance contingencies imposed by the department, and (c) any unearned incentive funds, to fund additional behavioral health services for children, families, and adults according to a plan developed with input from stakeholders, including consumers and their family members, the office of consumer affairs within the division, and the regional behavioral health authority and approved by the department. Such plan shall address the behavioral health needs of adults and children, including filling service gaps and providing system improvements;

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

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

(6) Provide that a minimum of one-quarter percent of the aggregate of all income and revenue earned by the contractor and related parties under the contract be at risk as a penalty if the contractor fails to meet the minimum performance metrics defined in the contract, and such penalties, if charged, shall be accounted for in a manner that shall not reduce or diminish service delivery in any way; and

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

Source: Laws 2012, LB1158, § 2.
Laws 2016, LB1011, § 1.

Appendix B: Heritage Health MCO Quality Performance Program Measures

Table B1: Heritage Health MCO Quality Performance Program Measures

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	15%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children: The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	68%[1]	10%
Well-Child Visits in the First 15 Months of Life: The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	66%[2]	10%
Childhood Immunization Status: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 29%[3] Combination #10 - 19%[3]	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Meningococcal – 77%[1] Tdap –85 %[1] HPV – 21%[1]	Meningococcal –3% Tdap – 3% HPV—4%
Cancer Screening: ***Breast Cancer Screening*** – The percentage of woman 50- 74 years of age who had a mammogram to screen for breast cancer. ***Cervical Cancer Screening*** – The percentage of women 21- 64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every 3 years, OR 2) Women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	BCS – 59%[1] CCS – 59%[1]	BCS—5% CCS--5%
Antidepressant Medication Management: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:	EAPT –76%[3] ECPT – 66%[3]	5%

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Effective Acute Phase Treatment – The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ***Effective Continuation Phase Treatment*** – The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).		
Follow Up Care for Children Prescribed Meds for ADHD- ADD: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: ***Initiation Phase*** – The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. ***Continuation and Maintenance (C&M) Phase*** – The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	IP – 46%[1] C&MP – 55%[1]	10%
Medication Management for People with Asthma: The percentage of Members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. For therapeutic purposes, the percentage of Members who remained on an asthma controller medication for at least 75% of their treatment period were monitored.	75% Med-adherent – 35%[1]	5%

[1] NCQA HEDIS 2016 Medicaid HMO Mean Reference Group; https://www.ncqa.org/hedis/measures.
[2] Medicaid Health Care Quality Measures Adult/Child Chart Pack Top Quartile Reference Group https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-chart-pack.pdf . https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html . (Well-Child Visits in the First 15 Months of Life: All MCOs met or exceeded mean NCQA Reference Group).
[3] MCO Aggregate Highest Performer + 5% (All MCOs met or exceeded both NCQA and Core Adult Set Reference Group Baseline).

Appendix C: DBPM Quality Performance Program Measures

Table C1: DBPM Quality Performance Program Measures

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the MCO receives the claim.	≥ 95% within 15 days	20%
Standard Service Authorizations: Process 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.	≥ 85% within 2 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the DBPM receives the appeal.	≥ 95% within 30 days	10%
Grievance Resolution Timeliness: The DBPM must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to Exceed ninety (90) calendar days from the day the DBPM receives the grievance.	≥ 95% within 60 days	10%

Appendix D: MCO Reporting Requirements

Table D1: MCO Reporting Requirements

Requirement	Description and Due Dates	
Bi-Weekly	Due the 1st and 15th of the month.	
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.	
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.	
Semi-Annual Deliverables	Due as specified in this attachment.	
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.	
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.	
• **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.** • **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**		
Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	Description	Due Date
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S – Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O - Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly

Requirement	Description and Due Dates	
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I - Provider Network Requirements and Attachment 39 - Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature by MLTC on Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit the data for these reports to MLTC as follows: Dec 15 (data from July 1 - Nov 30), March 15th (data from Dec 1 - Feb 28), June 15 (data from March 1 - May 31).
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly

Requirement	Description and Due Dates	
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 - Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O - Program Integrity, Section IV.S - Claims Management, and Section IV. T - Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification - In accordance With 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30

Requirement	Description and Due Dates	
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS - Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS - Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I - Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M - Quality Management.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

Appendix E: DBPM Reporting Requirements

Table E1: DBPM Reporting Requirements

Requirement	Description and Due Dates
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the calendar year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the DBPM.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third-Party Liability	All instances in which a TPL is identified for a member as described in Section IV.R – Claims Management.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.R - Claims Management.	15th day of the following calendar month
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

Requirement	Description and Due Dates	
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O – Program Integrity.	Second Friday of the following calendar month
All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the MCO	Summary of all referrals as described in Section IV.O – Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O – Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the MCO Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing DBPM member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Service Authorizations	Data summarizing DBPM compliance with timely service authorization requirements as detailed in Section IV.N. – Utilization Management.	15th day of the following calendar month
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	15th day of the following calendar month

Requirement	Description and Due Dates	
Quarterly Deliverables	**Description**	**Due Date**
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Care Coordination Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter
Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S – Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X – Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management Reviews	Summary data and analysis as detailed in Section IV.N – Utilization Management and as determined by MLTC.	45 calendar days following the most recent quarter

Requirement	Description and Due Dates	
Utilization Management Committee	Summary and meeting minutes for UM Committee meetings as described in Section IV.N – Utilization Management.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the MCO and MLTC.	45 calendar days following the most recent quarter
Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter
Administrative Performance Measures	Data and analysis summarizing results of Administrative Performance Measures as identified by MLTC.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Quality Management Program Description and Work Plan	Discussion of the MCO's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the calendar year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the calendar year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	120 calendar days following the 12th month of the calendar year
Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the calendar year
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the calendar year
Quality Performance Measures	Quality performance results as listed in Attachment 6 – Performance Measures.	Due dates to be provided prior to contract start and in accordance with reporting schedules for the governing entities.

Requirement	Description and Due Dates	
Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 calendar days prior to its administration.	120 calendar days following the 12th month of the calendar year
Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the calendar year
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the calendar year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	June 1
Network Development and Management Plan	Details of the MCO's network, including GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	30 calendar days following the 12th month of the calendar year
Utilization Management Program Review	Data and analysis summarizing the MCO's annual evaluation of it's UM program.	30 calendar days following the 12th month of the calendar year
Annual Staffing Report	Organization charts and staffing lists as detailed in Section IV.D – Staffing Requirements.	30 calendar days following the 12th month of the calendar year
QAPI Committee	Data and analysis addressing requirements detailed in Section IV.M – Quality Management.	30 calendar days following the 12th month of the calendar year

Appendix F: MCO Access Standards

Appointment Availability Access Standards

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

Geographic Access Standards

- The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties.
- The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members.
- The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs. In urban counties, a network retail pharmacy must be available within 5 miles of 90% of members' personal residences. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.
- The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.
- The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.
- The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the state on the basis of community standards.

Appendix G: DBPM Access Standards

Waiting Times and Timely Access

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

Geographic Access Standards

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

Appendix H: List of Acronyms

AABD: Aid to the Aged, Blind, or Disabled
ABD: aged, blind and disabled
ADD: attention deficit disorder
ADHD: attention deficit/hyperactivity disorder
APNs: advanced practice nurses
ATR: annual technical report
BCS: breast cancer screening
C&M: continuation and maintenance
C&MP: continuation and maintenance phase
CAC: Clinical Advisory Committee
CAHPS: Consumer Assessment of Healthcare Providers and Systems
CAP: corrective action plan
CCC: Children with Chronic Conditions
CCS: cervical cancer screening
CFR: Code of Federal Regulations
CHIP: Children's Health Insurance Program
CHIPRA: Children's Health Insurance Program Reauthorization Act
CM: care management
CMS: Centers for Medicare & Medicaid Services
DBH: Division of Behavioral Health
DBP: dental benefits program
DBPM: dental benefits program manager
DCFS: Division of Children and Family Services
DHHS: Nebraska Department of Health and Human Services
DMA: data management and analytics
DOs: doctors of osteopathic medicine
DQA: Dental Quality Alliance
DtaP: diphtheria, tetanus and acellular pertussis
DUR: Drug Utilization Review
EAPT: effective acute phase treatment
ECPT: effective continuation phase treatment
EES: Eligibility and Enrollment System
EQR: external quality review
EQRO: external quality review organization
ER: emergency room
FAD: fraud and abuse detection
FFS: fee-for-service
Flu: influenza
FWA: Fraud, Waste and Abuse
FQHC: federally qualified health centers
HCBS: home- and community-based services
HEDIS: Healthcare Effectiveness Data and Information Set
HepA: hepatitis A

HepB: hepatitis B
HHA: Heritage Health Adult Program
HiB: haemophilus influenza type B
HIPP: Health Insurance Premium Payment
HIS: health information system
HPV: human papillomavirus
IMD: institution for mental disease
IPRO: Island Peer Review Organization
IPSD: index prescription start date
IPV: polio
IRS: Internal Revenue Service
LB: legislative bill
LTC: long-term care
MAAC: Medical Assistance Advisory Committee
MAC: maximum allowable cost
MAR: management and administrative reporting
MCE: managed care entity
MCOs: managed care organizations
MDs: doctors of medicine
MLR: medical loss ratio
MLTC: Medicaid and Long-Term Care
MMC: Medicaid Managed Care Program
MMIS: Medicaid Management Information System
MMR: measles, mumps and rubella
MRO: Medicaid Rehabilitation Option
NAC: Nebraska Administrative Code
NCQA: National Committee for Quality Assurance
NE: Nebraska
NEMT: non-emergency medical transportation
NF: nursing facility
NHC: Nebraska Health Connection
NMPI: National Medicaid Pooling Initiative
NPIs: national provider identifiers
Ob/gyn: obstetrics/gynecology
PAHP: prepaid ambulatory health plan
PASRR: pre-admission screening and resident review
PCPs: primary care providers
PCV: pneumococcal conjugate
PDENT: Percentage of Eligible Population who Received Preventive Dental Services
PIPs: performance improvement projects
PMs: performance measures
PPACA: Patient Protection and Affordable Care Act
QAPI: quality assessment and performance improvement
QI: quality improvement

QM: quality management
QPP: Quality Performance Program
RFP: request for proposal
RHCs: rural health centers
RRP: Refugee Resettlement Program
RV: rotavirus
SHCN: special health care needs
SHIP: State Health Improvement Plan
SMI: serious mental illness
SSI: supplemental security income
SUDs: substance use disorders
SUR: surveillance and utilization review
Tdap: diphtheria toxoids and acellular pertussis
TPL: third-party liability
UM: utilization management
URAC: Utilization Review Accreditation Commission
VBP: value-based purchasing
VZV: varicella-zoster virus (chickenpox)
WIC: Women, Infants, and Children

Appendix I: Glossary of Key Terms

ACCESSNebraska: The state service delivery system for public benefits, accessible through a toll-free telephone number and website.

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

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

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

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

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

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

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

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

Fraud, Waste and Abuse (FWA): Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare.

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

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

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

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

Managed care organization (MCO): A private entity that contracts with MLTC to provide benefits and services to

Nebraska Medicaid enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Nebraska Department of Insurance with respect to licensure and financial solvency, and with respect to its products and services offered pursuant to the HERITAGE HEALTH is regulated by the Nebraska Department of Health and Human Services.

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

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

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

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

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

Nursing facility (NF): A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

National provider identifier (NPI): The name of the standard unique health identifier for health care providers.

Primary care provider (PCP): A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.

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

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

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

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

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

Third-party liability (TPL): Refers to the legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.