NE EQRO ANNUAL COMPLIANCE REVIEW
May 2018
Period of Review: September 1, 2017 – March 31, 2018
MCO: UnitedHealthcare Community Plan

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Care Management **General Requirements** The MCO must develop a care management program that focuses 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.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the following policies and procedures: Care Coordination and Transition Planning for Dual Eligible members and Receiving LTSS; Coordination with DHHS/DCFS for care of child; Special Consideration for Pregnant Member; Children and Youth with Special Health Care Needs: Care Coordination and Transition Planning; Coordination with Tribal Organization; Monitoring Emergency Service Utilization; Integration of Physical and BH Care; and Referral to DHHS Division of Behavioral Health Women's Set Aside Program.	
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: 1. 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 quality improvement. 2. Mental illness and substance use disorder are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings. 3. Many people suffer from both mental illness and substance use disorder. As care is provided, both	**Documents** Policy/procedure Program description Onsite discussion of how the MCO works with providers to ensure medical/behavioral health care integration and presentation of examples	Full	These requirements are addressed in the Care Management and Care Coordination policy; Integration of Physical and Behavioral Health Care; and Case Management Process.	

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illnesses must be understood, identified, and treated as primary conditions. 4. 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.	**Documents** Policy/procedure Program description	Full	The MCO submitted 12 different policies and procedures covering a wide variety of services that are provided. Such policies include EPSDT from Infancy to 30 Months Old Thereafter; Management of Care Transition; and Transitioning of Care from One Care Setting to Another.	
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.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the MCO's Care Management and Care Coordination policy. The Whole Person Centered Care Model (WPC) 2018 Program focuses on a holistic approach to an individual's care from providing appropriate health care services across the continuum, addressing individual needs to achieve quality outcomes, healthy lifestyle and empowering the individual. File Review Results Eleven (11) of 20 files had engaged members in self-management strategies and 9 files were not applicable.	
The MCO must identify members who require medium/intensive CM based on their chronic	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management and Care Coordination policy.	

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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.	Program description Evidence of identification of members requiring medium/intensive CM based on their chronic conditions		This policy specifies conducting a health risk assessment (HRA), which helps stratify members into the appropriate level of care. The policy also contains a tabular presentation that specifies the following: risk levels, characteristics of each level, and examples of services / interventions for each risk level. The Healthy First Step Program aims to identify pregnant members early on by identification and stratification and engaging the member as early as possible to ensure that they receive the care and services necessary to promote a healthy pregnancy and achieve better health outcomes for infants and children. As per the MCO, they don't just rely on the health assessments given to members but they also provide multiple calls to the members to help them assess and handle their needs including health education and referral to other community-based services. The MCO also utilizes provider claims, pharmacy claims, continuity of care and discussions with members as a tracking method for identifying member's whose clinical condition or social circumstances places them at a higher risk of eventually needing 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: 1. Ensuring that all covered services, including mental health or substance use disorder treatment services,	**Documents** Policy/procedure Program description Evidence of educating CM staff about available community resources View community resource tool/directory onsite	Full	These requirements are addressed in the Care Management and Care Coordination policy, where social determinants of health and how they affect members' health and wellness in each risk level are identified. The policy also specifies training of care management staff on an ongoing basis. The MCO's WPC Program incorporates the Emerging Risk Model as one	

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appropriate to a member's level of need, are available when and where the member needs them. 2. Ensuring that all care management 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. 3. Developing, subscribing to, or acquiring a tool accessible to its care management staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO shall make access to this information available to MLTC staff on request.			of the sources for identifying the 13 social determinants using direct and indirect measures.	
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.	**Documents** Evidence of MCO staff training including agendas, meeting materials and attendance records	Full	This requirement is addressed in the monthly lunch-and-learn topics discussed by the MCO with their staff through PowerPoint presentations and brochure distributions. These topics include social determinants such as food insecurity, job training, housing, health, safety and security, wellness, homeless prevention, and transportation needs. The MCO conducts a four month intensive training for all new hires, so that they are able to conduct comprehensive assessments, and appropriately evaluate and manage the health and wellbeing of members.	
The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the MCO's Healthy First Steps Program. This program utilizes information technology platforms and	

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components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.			clinical management systems, along with member data (including demographic, eligibility, program enrollment, claims, and utilization information), in order to enable staff to facilitate coordination of care for members directly as well as through their health care provider.	
As part of the CM system, the MCO must employ care coordinators and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to a member.	**Documents** Position descriptions for care coordinator and care manager Organizational chart for CM department	Full	This requirement is addressed in the job description for HSS Clinical Coordinator and the job description for the Care Navigator.	
The MCOs must submit policies and procedures specific to care management 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.	**Documents** Policies/procedures	Full	This requirement is addressed in the policies and procedures for the following: Care Coordination and Transition Planning for Dual Eligible Members and receiving LTSS; and Coordination with MLTC Programs and Other Community-Based Services.	
In addition, the MCO must annually review, and update as necessary, with the input, review, and approval of the Clinical Advisory Committee (CAC), the CM policies and procedures. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.	**Documents** Evidence of CAC approval of CM policies and procedures Evidence of MCO staff training including agendas, meeting materials and attendance records Evidence of sharing policies/procedures with providers	Full	This requirement is addressed in the MCO's minutes for their Clinical Advisory Committee meetings held 11/07/17 and 02/27/18. These minutes contained the agenda, meeting materials as well as the attendance record. The MCO also conducted Behavioral Health Advisory Committee meetings on 11/16/17 and 02/15/2018.	
Health-Risk Screening/Assessment The MCO must provide a health-risk screening to all members on enrollment to identify members in need of CM services.	**Documents** Policy/procedure Template screening instrument **Reports**	Full	This requirement is addressed in the Care Management and Care Coordination policy, which stipulates that the MCO conducts the health risk assessment during the new member	

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	Examples of CM reports showing completion rates by new enrollees		welcome call. The MCO also utilizes a screening tool for the adult and pediatric populations.	
As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of CM services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in the MCO's Care Management and Care Coordination policy.	
Health-risk assessments must be developed to collect information such as, but not limited to: 1. Severity of the member's conditions/disease state. 2. Co-morbidities, or multiple complex health care conditions. 3. Recent treatment history and current medications. 4. Long-term services and supports the member currently receives. 5. Demographic and social information (including ethnicity, education, living situation/housing, legal status, employment status, food security). 6. Activities of daily living (including bathing, dressing, toileting, mobility, and eating). 7. Instrumental activities of daily living (including medication management, money management, meal	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the MCO's Care Management and Care Coordination policy and Identification of High Risk Members for Case Management policy. File Review Results Twenty (20) of 20 files reviewed contained health risk assessments.	

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preparation, shopping, telephone use, and transportation). 8. Communication and cognition. 9. Indirect supports. 10. General health and life goals. 11. Safety (need for welfare/protection to eliminate harm to self or others). 12. The member's current treatment providers and care plan, if applicable. 13. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma. 14. Substance use, including alcohol. 15. Interest in receiving CM services.				
The MCO must assign members to risk stratification levels (low, medium, high), which determines the intensity of intervention levels and follow-up care required for each member.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Prior Results (2017) Substantial-18 of 20 files included a risk stratification level, 1 file did not include a risk stratification level, and 1 file was not applicable. MCO Response UnitedHealthcare Community Plan has met this requirement, as risk scores are tabulated with proprietary algorithms which include data from a variety of sources such as claims, authorizations, and health assessments. If a member does not have sufficient data in their record then the score may not be calculated.	

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			The Health Plan identified members for care management according to population group/needs as well as mandates from MLTC such as fosters/wards, so some members may have been identified for care management prior to enough data accumulating for a risk score to be calculated. IPRO Response It is not possible to determine whether the file that was missing a risk score was due to lack of sufficient information needed to compute this score, or failure to include this score. For members with insufficient data to compute this score, it should be noted within the chart. This requirement is addressed in the Care Management and Care Coordination policy and Identification of High Risk Members for Case Management policy. File Review Results Twenty (20) of 20 files reviewed were assigned to a risk stratification level. Two (2) of 20 were high risks and 18 were medium risk.	
The MCO must ensure that members who have high costs or potentially high costs, or otherwise qualify, be assigned to the medium or high risk level and receive more intensive CM services.	**Documents** Policy/procedure Onsite presentation of case assigned to medium or high risk level based upon high costs or potentially high costs	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management and Care Coordination policy.	

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The MCO must conduct ongoing predictive modeling to identify members who may need CM evaluation.	**Documents** Policy/procedure **Reports** Examples of predictive modeling reports	Full	This requirement is addressed in the policy for Identification of High Risk Members for Case Management.	
Behavioral Health Principles of Care The MCO must ensure that "active treatment" is being provided to each member. Active treatment includes implementation of a professionally-developed and supervised individual plan of care, in which the member participates and shows progress.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Prior Results (2017) Substantial-18 of 20 files included an individual plan of care. Two (2) files were not applicable. Of the 18 files with a plan of care, 1 file did not demonstrate monitoring of progress towards goals, e.g., monitoring and updating of the plan of care. MCO Response UnitedHealthcare Community Plan has met this requirement. It has a Plan of Care SOP which requires staff to monitor progress towards goals. The Plan of Care SOP was re-reviewed with the CM/CN team during the CM/CN staff meeting on 11/8/17 to reinforce the standard procedures for updating a member's plan of care. IPRO Response Although UHCCP has a Plan of Care SOP, evidence of ongoing monitoring and updating of the member's care plan was not provided in 1 of the 18 applicable records reviewed. This requirement is addressed in the Care Management and Care Coordination policy, where the care manager develops a proposed plan of care with the member in collaboration with the member's family, PCP and interdisciplinary care team. The individual care plan is revised at least quarterly and with	

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			significant change in condition. These revisions and outcomes are documented in the care management documentation system. File Review Results Eleven (11) of 20 files had an individual plan of care and 9 files were not applicable.	
Basic CM Services The MCO must develop and adopt a CM program consistent with existing State policies and procedures to ensure all members who are eligible for CM have access to basic CM services.				
The MCO's basic CM program must promote empowerment of the person and shared decision making. Examples of basic level CM services the MCO may provide include: 1. Assistance with appointment scheduling and identifying participating providers, when necessary.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy where members are given assistance to ensure timely and coordinated access to providers and covered services. The requirement is also addressed in the WPC program, which incorporated the goal to empower members by providing resources, guidance and tools needed to make informed personal health choices and decisions. File Review Results Four (4) of 20 files demonstrated that members were provided assistance with appointment scheduling. Sixteen (16) files were not applicable.	
2. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the Care Management and Care Coordination policy where members are given assistance to ensure	

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	Onsite File Review CM file review results		timely and coordinated access to providers and covered services. File Review Results Eight (8) of 20 files demonstrated that members were provided assistance in accessing primary care or specialty care. Twelve (12) files were not applicable.	
3. Coordination of discharge planning with a focus on the seriously mentally ill population.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy. When members are discharged from inpatient and residential treatment levels of care, including state psychiatric hospitals, care will be coordinated to ensure that appropriate services are in place to meet the member's needs. File Review Results One (1) of 20 files demonstrates coordination of discharge planning. Nineteen (19) files were not applicable.	
4. Coordination that links a member to providers, medical services, or residential, social, community, and other support services, when needed.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in the policy for Coordination with MLTC Programs and other Community-Based Services	
5. Continuity of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy in section G – Transition of Care Policy and Procedure for Management of Care Transition. File Review Results	

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care activities must provide processes by which MCO members and network/non-network provider interactions are effective and must identify and address those that are not.			Five (5) of 20 files demonstrated continuity of care. Fifteen (15) were not applicable.	
6. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy – section B Community Resources. File Review Results Seven (7) of 20 files demonstrated that members were provided assistance with referral to community resources. Thirteen (13) were not applicable.	
7. Following up with members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.	**Documents** Policy/procedure Program description Examples of follow-up with members and providers	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
The MCO must develop and adopt policies and procedures annually to address the following: 1. A strategy to ensure that all members and/or authorized family members or guardians are involved in care planning, as appropriate.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy File Review Results Eleven (11) of 20 files have shown that members or their authorized family member were involved in care planning. Nine (9) files were not applicable.	
2. A method to actively engage members in need of CM who are unresponsive to contact attempts or disengaged from CM.	**Documents** Policy/procedure Onsite discussion of methods used	Full	This requirement is addressed in the Care Management and Care Coordination policy.	

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3. An approach that uses pharmacy utilization data to tailor CM services.	**Documents** Policy/procedure Evidence of using pharmacy utilization data to tailor CM services	Full	This requirement is addressed in the Care Management and Care Coordination policy. Members are initially stratified into high, medium or low risk based on multiple sources of data including but not limited to HRA data, practitioner referrals, UM data, medical claims data, pharmacy claims data, data from wellness program, and information from EHR and member referrals.	
4. An approach to encourage participation in CM activities by, and collaboration among, the following providers: a. PCPs and behavioral health providers. This includes policies that ensure that PCPs refer members to behavioral health specialists when SMI is present or the member identifies as having a SMI. b. HCBS service coordinators. c. Community support providers.	**Documents** Policy/procedure Description of approach for encouraging participation in CM activities and collaboration among providers	Full	This requirement is addressed in the policy for Coordination with MLTC Programs and other Community-Based Services. The MCO continuously outreaches to all providers. They also provide continuous education about transition of care to providers and, as needed, enlist their provider advocates for better collaboration.	
5. Procedures and criteria for making referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must (a) provide the coordination necessary for referral of MCO members to specialty providers to determine the need for services outside the MCO network and (b) refer a member to the appropriate service providers.	**Documents** Policy/procedure	Full	This requirement is addressed in the policy for Out of Network Requests and Continuing Care, and in the policy for Continuity-Coordination of Care.	
6. Results of the identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated and to identify any	**Documents** Policy/procedure	Full	This requirement is addressed in the policy for Assessment of the Quality and Appropriateness of Care for Members with SHCN.	

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ongoing special conditions that require a course of treatment or regular care monitoring.				
7. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	**Documents** Policy/procedure	Full	This requirement is addressed in the policy for Management of Care Transition, and in the Care Management and Care Coordination policy.	
8. Documentation of referral services and medically indicated follow-up care in each member's medical record.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	This requirement is addressed in the policy for Management of Care Transition, which references that the PCP maintains medical records in accordance with health plan standards. This includes continuity and coordination of care documentation such as referrals, coordination across care settings, consultation with providers, follow-up on unresolved problems, follow-up on missed appointments and communication with referring practitioner.	
9. Documentation in the member's medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	This requirement is addressed in the policy for Management of Care Transition.	
10. A process that ensures that when a provider is no longer available through the MCO, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional 90 calendar days to ensure continuity of care.	**Documents** Policy/procedure	Full	This requirement is addressed in the policy for Continuity-Coordination of Care.	
11. A process that ensures continuity of care for members with SHCNs who are in CM.	**Documents** Policy/procedure	Full	This requirement is addressed in the following policies; Children and Youth with Special Health Care Needs, Care Coordination and Transition Planning, and Assessment of the Quality and	

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			Appropriateness of Care for Members with SHCN.	
For members assigned to medium risk care management, the MCO must meet basic care management requirement and: 1. Facilitate relapse prevention plans for members with depression and other high-risk behavioral health conditions and their PCPs (e.g., patient education, extra clinic visits, or follow-up telephone calls).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy, which cites facilitation of relapse prevention plans, including education, extra clinic visits or follow-up telephone calls for members with depression and other behavioral health conditions. File Review Results Twelve (12) of 20 files demonstrated facilitation of relapse prevention. Eight (8) files were not applicable.	
2. Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.	**Documents** Policy/procedure Onsite discussion	Full	Prior Results (2017) Substantial- This requirement is addressed in NE HS 020, Care Management and Care Coordination. Pharmacy utilization data and profiling are reviewed by the Pharmacy & Therapeutics Committee. UHCCP has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. Per the MCO, methods of sharing of these practices will be through outreach to providers and possible postings with the NE Pharmacist Association. MCO Response UnitedHealthcare Community Plan has met this requirement. Please see the Narrative labeled 2017 NE EQRO Narrative - Medication Adherence.	

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			IPRO Response The documentation that was provided did not show evidence of partnering with provider practices with high medication adherence rates, to identify best practices that can then be shared with practices having lower adherence rates. This requirement is addressed in the Care Management and Care Coordination policy.	
3. Educate provider office staff about symptoms of exacerbation(s) and how to communicate with patients.	**Documents** Policy/procedure Examples of education provided to office staff	Full	This requirement is addressed in the Care Management and Care Coordination policy. Further, the MCO conducted their Spring Provider Forum in March 2018.	
4. Develop speaking points and triggers for making emergency appointments.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
5. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors, or unmet needs.	**Documents** Policy/procedure Examples of forms and monitoring tools	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
For members assigned to high risk care management, the MCO must meet requirements for members assigned to low and medium risk care management and the MCO must develop and adopt policies and procedures for the following: 1. As appropriate, organize the care using a person-centered, inter-disciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, that are in accordance with State QI and UM standards.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy. File Review Results Two (2) of 20 files demonstrated a person centered care plan. Eighteen (18) files were not applicable.	

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2. Provide list of community resources (for referral).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy. File Review Results Two (2) of 20 files demonstrated that the member was provided with a list of community resources. Eighteen (18) were not applicable.	
3 Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
4. Develop a process to engage non-compliant members.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy and Policy and Procedure for Unable to Reach File Review Results One (1) of 20 files demonstrated a process to engage the non-compliant member. Nineteen (19) files were not applicable.	
5. Develop a strategy for communication with members and their families, as well as key service and support providers and local social and community service agencies.	**Documents** Communication strategy	Full	This requirement is addressed within the MCO's Member Education Plan Overview materials. The MCO utilizes the member newsletter and Member Handbook to communicate with members and their families, and also rely on outreach methods such as health fairs.	
6. Identify providers with special accommodations (e.g., sedation dentistry).	**Documents** Policy/procedure Provider directory	Full	This requirement is addressed in the Care Management and Care Coordination policy, and within the Provider Directory.	
7. Educate staff about barriers members may experience in making and keeping appointments.	**Documents** Evidence of staff education	Full	Prior Results (2017) Substantial- Staff training is addressed in NE HS 020, Care Management and Care Coordination.	

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Training documents provided do not address barriers members may experience in making and keeping appointments. MCO Response UnitedHealthcare Community Plan has met this requirement. Individual training topics related to barriers members may experience in making and keeping appointments were organized into an infographic tool titled 'How to Address Doctor Appointment Barriers'. The infographic tool refers to motivational interviewing training Care Management staff receive and contains links to review materials on non-emergency medical transportation, translation services, and the nurse line. The infographic tool also provides guidance on documentation in the member record and follow up pertaining to the intervention used by the Care Manager/Navigator to address the doctor appointment barriers. Care Management staff was provided the consolidated infographic on 11/16/2017 and completed an attestation of receipt. IPRO Response The infographic training resource was developed and disseminated to staff outside of the audit period. This requirement is addressed in the education the MCO provides to each of their staff, titled How to Address Doctor's Appointment Barriers. The MCO also provides staff with a simplified guide / diagram to address such barriers. In November 2017, 26 staff members	

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			received education about the topic regarding barriers members may experience in making and keeping appointments.	
8. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
9. Communicate on a member-by-member basis on gaps/needs to ensure that a member obtains baseline and periodic medical evaluations from his/her PCP.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy. File Review Results Two (2) of 20 files demonstrated that communication was provided. Eighteen (18) files were not applicable.	
The MCO must develop, implement, and evaluate written policies and procedures consistent with existing State policies and procedures, regarding continuity of care. In particular, the policies and procedures must address the following situations: 1. Members whose treating providers become unable to continue service delivery for any reason. 2. Member transitions from the children's system to the adult system. 3. Member transitions to/from IHS or other tribal agencies. 4. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.	**Documents** Policies/procedures	Full	This requirement is addressed in the following policies: Care Management and Care Coordination, Continuity-Coordination of Care, and Coordination with Tribal Organization. The MCO also has standard operating procedures for member follow-up post-discharge from the hospital.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with Providers and Other CM Programs Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other State programs are likely to have one or more case or care managers. The MCO must demonstrate an understanding of health care and social service programs and initiatives offered by MLTC and other State agencies, and 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.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Care Management and Care Coordination policy, and in the Coordination with MLTC Programs and Other Community-Based Services policy.	
The MCO must attempt to ascertain whether a member has any other case or care managers, and, if so, to engage with them. The MCO must also attempt to ascertain whether a member has any other identified caregivers in the member's care planning and CM, and, if so, to engage with them.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	This requirement is addressed in the Care Management and Care Coordination policy and Coordination with MLTC Programs and Other Community-Based Services. File Review Results Twenty (20) of 20 files demonstrated that an attempt was made to determine whether a member had any other care manager or other identified caregiver.	
The MCO is responsible for ensuring coordination between its providers and the WIC program.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management and Care Coordination policy.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.				
The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Care Management and Care Coordination policy.	
Coordination with HCBS Service Coordinators The MCO must collaborate and coordinate with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports. The MCO must develop a policy and procedures for coordination with HCBS case managers. This policy and these procedures must address methods the MCO will use to ensure that coordination services are not duplicated.	**Documents** Policy/procedure	Full	This requirement is addressed in the Care Management and Care Coordination policy and Coordination and Coordination with MLTC Programs and Other Community-Based Services policy.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with Tribal Organizations The MCO must develop policies for care coordination/collaboration for members who are Tribal members or are eligible for care through IHS or other Tribally-funded health and human services program, including: 1. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes. 2. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network. 3. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally-operated facility/ program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638. 4. Development of methods for regular planning to coordinate on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate health service delivery.	**Documents** Policy/procedure	Full	These requirements are addressed in the policy Care Management and Care Coordination, and in Direct Access for Native Americans and Coordination with Tribal Organizations.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with the Division of Children and Family Services The MCO must develop processes and procedures for collaboration with the Division of Children and Family Services for children who are in foster care placement. CM must include collaborating with 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: a. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice. b. How health needs identified through screenings will be monitored and treated. c. How medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record. d. Steps to ensure continuity of health care services. e. The oversight of prescription medications.	**Documents** Policy/procedure	Full	This requirement is addressed in the policy Coordination with DHHS/DCFS for Care of Child.	

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Provider Network Requirements **General Provider Network Requirements** The network must be supported by written contracts between the MCO and its providers.	**Documents** Template provider contract – one per provider type	Full	UHCCP provided their provider contracts, one per each provider type, as evidence of compliance with this requirement.	
The MCO 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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Appointment and Wait Time Monitoring Policy. It is communicated to the providers in their provider contract and in the Provider Manual. UHCCP submitted their provider contracts, one per each provider type, as evidence of compliance with this requirement.	
There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.	**Documents** Policy/procedure	Full	This requirement is addressed in the Adequate Capacity and Services Policy on page 1.	
The MCO must have available non-emergent after-hours physician or primary care services within its network.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the Adequate Capacity and Services Policy. The MCO provided screen shots of the hours of operation screen for its online provider directory as evidence of compliance with this requirement.	
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 Attachment 39 – Revised Access Standards. The MCO must ensure that providers are available within these requirements. **Attachment 39:** Appointment Availability Access Standards	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Appointment and Wait Time Monitoring Policy. The Provider Manual communicates this requirement to the providers. UHCCP provided the Provider Network Access and Provider Network PCP Access spreadsheet which shows compliance with all areas of Attachment 39 as referenced in this requirement.	

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1. 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. 2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO. 3. 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. 4. Family planning services must be available within seven calendar days. 5. Non-urgent, preventive care must be available within 4 weeks. 6. 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. 7. 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 one month of referral or as clinically indicated.			UHCCP submitted their provider contracts, one per each provider type, as evidence of compliance with this requirement.	

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8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care. 9. 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. <u>Geographic Access Standards</u> 1. 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. 2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics. 3. 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.				

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a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences. b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences. c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences. 4. 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. 5. 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.				

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census. 7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.				
The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in the Appointment and Wait Time Monitoring Policy.	
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.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed on page 13 of the Network Development Plan. The plan contracts will all willing providers. The MCO provided a screen shot of the interactive provider directory as evidence of compliance with this requirement.	
In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	UHCCP provided their provider contracts, one per each provider type, as evidence of compliance with this requirement.	

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advertise or otherwise hold itself out as having an exclusive relationship with any provider.				
The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters.	**Documents** Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Manual on pages 2 through 18.	
The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the Provider Manual on pages 2 through 18.	
The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the Provider Manual on pages 1 through 9.	
Provider Discrimination Prohibition A MCO may not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider who/that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification.	**Documents** Policy/procedure Provider manual	Full	This requirement is addressed in section 4.3 of the Provider Agreement Appendix.	
MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Documents** Policy/procedure Provider manual	Full	This requirement is addressed in section 4.3 of the Provider Agreement Appendix.	
If a MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision.	**Documents** Policy/procedure	Full	This requirement is addressed in the Credentialing Plan.	

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Federal requirements at 42 CFR 438.12(b) shall not be construed to: 1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members. 2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. 3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to its members.				
Mainstreaming of Members To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f):	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Mainstreaming Members Policy. This policy addresses ways in which the MCO takes into account a member's literacy level and culture when addressing their concerns. The Vendor Management Policy and subcontractor agreement also address this requirement.	

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1. Denying or not providing a member any covered service or access to an available facility. 2. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary. 3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service. 4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.				
If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full	This requirement is addressed in the Vendor Management and Oversight Policy.	
If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider. Failure to take prompt	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Manual and the Credentialing Plan.	

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corrective measures shall subject the MCO to intermediate sanction or contract termination.				
Establishing the Network The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement at contract start date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.	**This r**	Full	The MCO provided Q4 2017 GeoAccess Reports to satisfy this requirement.	
The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, 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.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Network Development Plan and in the MCO's submission of the Q4 2017 GeoAccess Reports.	
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	**Documents** Policy/procedure	Full	This requirement is addressed in the Q4 2017 GeoAccess Reports.	

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members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or 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's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members. In addition, the MCO must make a good faith effort to include providers currently contracted with behavioral health regions in Nebraska.	Onsite discussion	Full	The MCO has made efforts to contract with all willing providers currently contracted with behavioral health regions in NE.	
The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Direct Access to Women's Specialists Policy.	
For members who meet SHCN criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Whole Person Care Program Description.	

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The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions: 1. Co-occurring mental health and substance use disorders. 2. Co-occurring mental health and substance use disorders and developmental disabilities. 3. Serious and persistent mental illness. 4. Severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities, etc.). 5. Sex-offending behaviors. 6. Eating disorders. 7. Co-occurring serious mental illness (SMI) and common chronic physical illnesses.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Network Development Plan. The MCO has made efforts to contract with all willing providers with experience and expertise in the applicable behavioral health fields.	
If any service or provider type is not available to a member within the mileage radius specified in Attachment 39 – Revised Access Standards, the MCO must submit to MLTC, for approval a minimum of 45 calendar days prior to implementation, verification that the covered services are not available within the required distance.	**Documents** Policy/procedure Examples of notification to MLTC	Full	The MCO provided their Single Case Agreements for Medicaid Standard Operating Procedure as evidence of the steps it takes to provide services to members when that service or provider type is not available to a member.	

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The MCO is not precluded from making arrangements with a provider outside the State for members to receive a higher level of skill or specialty than the level that is available within the State.	**Documents** Policy/procedure	Full	The MCO offers to contract with every willing provider in and out of state.	
Contracting with FQHCs and RHCs A MCO must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.	**Reports** Geo access reports Onsite discussion	Full	This requirement is addressed in the Network Development Plan.	
Adequate Capacity When establishing and maintaining the network, the MCO must consider: Its anticipated Medicaid enrollment. The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. The numbers of network providers who/that are not accepting new Medicaid patients. The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	**Documents** Policy/procedure Network development plan Onsite discussion	Full	This requirement is addressed in the Network Development Plan.	

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State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.				
Appointment Availability and Referral Access Standards Nebraska's appointment availability standards are included in Attachment 39 – Revised Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 38 – Revised Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.				
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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Appointment Availability and Wait Time Policy and Procedure. The MCO submitted its provider contracts which also address this requirement. This requirement is communicated to the providers in the Provider Manual.	
Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Manual as well as in the provider and facility agreements.	

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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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual Member Handbook	Full	This requirement is addressed in the Provider Manual as well as in the provider and facility agreements.	
The MCO is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment availability including results and f/u actions	Full	This requirement is addressed in the Appointment Monitoring and No Show Reduction Policy.	
The MCO 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 MCOs.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment "no-show" rate including results and f/u actions	Full	This requirement is addressed in the Appointment Monitoring and No Show Reduction Policy.	
The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO 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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual **Reports** Evidence of monitoring of waiting lists including results and f/u actions	Full	UHCCP does not require referrals and maintains an open network for members. The MCO ensures that providers are accessible through the Appointment Monitoring and No Show Reduction Policy. The MCO also monitors open and closed panels and their grievance logs to ascertain whether members have complaints about provider waiting lists.	

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Geographic Access Standards The MCO must comply with maximum travel times and/or distance requirements per Attachment 39 – Revised 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.	**Documents** Policy/procedure Requests for exception submitted to MLTC **Reports** Evidence of Geo access monitoring including results and f/u actions	Full	The MCO submitted its Geo Access Q4 2017 report. UHCCP contracts with every willing provider. Geo Access Access was between 70-80 percent in the following areas: BH Inpatient - *Frontier* – 76% Allergy and Immunology - *Frontier* – 77% Dialysis Center - *Frontier* – 79% Between 60-69 percent in the following areas: FQHC - *Rural* – 69% Gastroenterology - *Frontier* – 63% Infectious Disease - *Frontier* – 65% Less than 60 percent in the following areas: BH Residential - *Frontier* – 45% FQHC - *Frontier* – 10% Pediatrics - *Frontier* – 58% Urgent Care - *Frontier* – 54% Neurosurgery - *Frontier* – 48% Rheumatology - *Frontier* – 55%	

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If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith attempts, for example) 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.	**Documents** Policy/procedure Provider network availability plan	Full	This is addressed in the Network Development Plan. The MCO contracts with every willing provider.	
The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.	**Documents** Policy/procedure Provider network availability plan **Reports** Evidence of monitoring utilization including results and f/u actions	Full	The MCO provided its Geo Access Reports for Q4 2017 as evidence that it monitors utilization across the state.	
Provider Credentialing and Re-Credentialing The MCO 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.	**Documents** Policy/procedure	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum.	
The MCO 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 MCO must: 1. Review, approve, and load approved providers to its provider files in its system and submit the	**Documents** Policy/procedure Template denial letter	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum. The MCO provided a sample denial letter as evidence of its compliance with this requirement.	

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
information in the weekly electronic provider file to MLTC or MLTC's designee, or 2. Deny the application and ensure that the provider is not used by the MCO. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.				
The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO 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.	**Documents** Policy/procedure	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum.	
The MCO 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.	**Documents** Policy/procedure **Onsite file review** Credentialing file review results	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum. Credentialing File Review Results Ten (10) of 10 files met all requirements.	
The MCO must re-credential each provider a minimum of every three (3) years, at a minimum, taking into consideration various forms of data, including but not limited to grievances, results of	**Documents** Policy/procedure **Onsite file review**	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum. Re-credentialing File Review Results	

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
quality reviews, results of member satisfaction surveys, and utilization management information.	Re-credentialing file review results		Ten (10) of 10 files met all requirements.	
The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.	**Documents** Policy/procedure	Full	This requirement is addressed in the Credentialing Plan and Regulatory Addendum. This requirement is also addressed in the Network Compliance and Quality Service Monitoring Policy.	
Network Administration The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider: 1. Network provider name 2. Contracted services 3. Site address(as) (street address, city, zip code, region of the State) 4. Site telephone numbers 5. Site hours of operation 6. Emergency/after-hours provisions 7. Professional qualifications and licensing; 8. Areas of specialty, including specialties related to behavioral health conditions 9. Cultural and linguistic capabilities	**Documents** Policy/procedure View network provider database onsite	Full	This requirement is addressed in the Medicaid Participation Requirements Policy. Onsite, the MCO provided a demonstration of the provider database which contains all required elements.	

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10. Malpractice insurance coverage and malpractice history 11. Credentialing status				
The MCO must have the capability to produce a list of network providers, sorted by type of service and by providers' capability to communicate with members in their primary languages. This list must be available to the MCO's clinical staff at all times, and available to network providers and other interested parties upon their request and at no charge. As described in the Member Services section of this RFP, this list must be available on the MCO's website and updated in real time.	**Documents** Policy/procedure View website onsite	Full	The UHCCP website allows members to produce a list of network providers and sort that list by service and language.	
Network Development Plan Future network development plans must be submitted by November 1st of each contract year. This document is an assurance of the adequacy and sufficiency of the MCO's provider network. The MCO must also submit, as needed, an updated plan when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
The MCO must include in its stated future plans a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis must be derived from: Quantitative data, including performance of appointment standards/appointment availability,	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	

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eligibility/enrollment data, utilization data, network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case contracts by service type.				
Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
A summary of network development efforts conducted during the prior year.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
Plans to correct any current material network gaps and barriers to network development.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	
The participation of members, family members/caretakers, providers, including State-operated providers, and other community stakeholders in the annual network planning process.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Network Development Plan.	

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Provider Network Policies and Procedures The MCO must have policies about how it will: Communicate with the network regarding contractual and/or program changes and requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Communications Policy and Procedure.	
Monitor network compliance with State rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes.	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Compliance and Quality Service Monitoring Policy.	
Evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full	This requirement is addressed in the Annual Assessment of Network Adequacy documentation.	
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.	**Documents** Policy/procedure	Full	This requirement is addressed in the Adequate Capacity and Services Policy.	
Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.	**Documents** Policy/procedure	Full	This requirement is addressed in the Adequate Capacity and Services Policy and in the Network Access and Cultural Competency Report.	
Process provisional credentials for behavioral health service providers.	**Documents** Policy/procedure	Full	This requirement is addressed in the Addendum to Credentialing Policies.	
Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling.	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Development Plan.	

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Provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Education and Training Policy.	
Educate its provider network regarding appointment time requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in the Provider Manual and in the Appointment wait Time Monitoring Policy. The MCO provided the Provider Education Activity report as evidence of compliance with this requirement.	
Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.	**Documents** Policy/procedure **Reports** Evidence of tracking/trending of provider inquiries/complaints/requests for information including results and f/u actions	Full	The MCO tracks and trends its provider inquiries, complaints and requests in the Member-Provider Call Center Stats documentation.	
Provider-Patient Communication/Anti-Gag Clause Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following: a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the member needs in order to decide among relevant treatment options.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Manual and in the facility and provider agreements.	

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
c. The risks, benefits, and consequences of treatment or non-treatment. d. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1) will be subject to intermediate sanctions. The MCO must comply with the provisions of 42 CFR 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to physician incentive plans.				
Confidentiality The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Manual and in the facility and provider agreements.	

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Provider Complaint System A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	**Documents** Policy/procedure	Full	Provider Complaints are defined on page 27 of the Provider Appeals and Complaints Policy. UHCCP uses the ETS escalation tracking system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	
This system must be capable of identifying and tracking complaints received by telephone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	**Documents** Policy/procedure **Reports** Provider complaint system reports produced during the review period	Full	UHCCP's Escalation Tracking System is capable of tracking complaints taken in any form.	
The MCO must prepare and implement written policies and procedures that describe its provider complaint system. The policies and procedures must include, at a minimum: 1. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes. 2. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function.	**Documents** Policy/procedure Provider manual Template complaint resolution notice **Onsite File Review** Provider complaint file review results	Full	This requirement is addressed in the Provider Complaint and Claims Dispute System. The Provider Appeals and Complaints Policy describes the MCO's provider complaint system. The ETS is used to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system captures and tracks all provider complaints, whether received by telephone, in person, or in writing. Provider Complaint File Review Results Ten (10) of 10 files met all requirements	

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3. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf. 4. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues. 5. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation. 6. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary. 7. A process for giving providers (or their representatives) the opportunity to present their cases in person. 8. Identification of specific individuals who have authority to administer the provider complaint process. 9. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.				

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The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.	**Documents** Policy/procedure Provider manual View website onsite	Full	The instructions on how to contact the MCO with a complaint is found on page 11 of the Provider Manual. Onsite, the MCO provided a demonstration of the provider website which included instructions regarding how to contact provider services.	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Subcontracting Requirements As required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3), the MCO 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 MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	**Documents** Policy/procedure List of subcontractors including scope of services provided and date of initial delegation **Reports** Pre-delegation evaluation report for each subcontractor contracted with during the review period Also includes reviewer completion of subcontractor worksheet	Full	This requirement is addressed in the UnitedHealthcare Clinical Services Delegated Credentialing Oversight Policy on pages 2 through 4. UHCCP provided a list with 16 active subcontractors. All 16 subcontracts pre-dated the review period and, therefore, the requirement for pre-delegation evaluation was not applicable.	
The MCO must have a written contract between the MCO 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.	**Documents** Contract with each subcontractor Also includes reviewer completion of subcontractor worksheet	Full	UHCCP provided subcontractor agreements (contracts) for the 16 active contractors which addresses this requirement.	
The MCO 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.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	This requirement is addressed in the UnitedHealthcare Clinical Services Delegated Credentialing Oversight Policy on pages 2 through 4. This requirement is addressed per evidence demonstrated by the MCO that they conducted ongoing monitoring of their 16 subcontractors. Specifically, UHCCP provided regular and scheduled reports, annual assessments, and compliance committee minutes evidencing ongoing monitoring the performance of subcontractors.	

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State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	This requirement is addressed in the Vendor and Delegated Entity Oversight Policy on pages 3 through 4 and throughout the UCSMM 03.14 Delegated Credentialing Oversight Policy & Procedure as "Improvement Action Plan (IAP)." UHCCP identified deficiencies in 1 of 16 subcontractors, and subsequently took corrective action. The corrective action plan (CAP) was initiated in 9/16/2017 with a projected end date of 3/31/2018. Onsite, the MCO confirmed that the CAP was completed in January 2018. UHCCP explained that the subcontractor was required to carry out additional training for the CAP and document this training to the MCO, which they did. UHCCP also required the subcontractor to provide certifications for reporting as well as revised/additional policies, which the subcontractor was able to provide. No deficiencies were identified for the remaining 15 subcontractors.	

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Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Member Rights and Protections **Member Rights** The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC 7-001. At a minimum, each MCO member is guaranteed the right to: a. Be treated with respect and consideration of his/her dignity and privacy. b. Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information. c. Participate in decisions regarding his/her health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO. d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. e. Request and receive a copy of his/her medical records, and request that they be amended or corrected as specified in 42 CFR 438.100. f. Obtain available and accessible health care services covered under the contract. g. Request disenrollment per 42 CFR 438.56.	**Documents** Policy/procedure Member Handbook	Full	These requirements are addressed in the Policy and Procedure for Mainstreaming Members within the procedure section. These requirements are also addressed on page 106 of UHCCP's Member Handbook.	
Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on pages 106 and 119.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.	Member Handbook			
Indian Health Protections Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, the MCO must: Permit any American Indian who is enrolled in a MCO and eligible to receive services from a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his/her PCP, as long as that provider has the capacity to provide the service. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.	**Documents** Policy/procedure **Reports** Provider adequacy report for I/T/U providers	Full	This requirement is addressed in the Policy and Procedure for Direct Access for Native Americans. The requirement is also addressed on page 1 of the Indian Health Services Access Report 2017. There are 6 listed Contracted Tribal Providers Clinics in the 6 cities of NE which represents 100% of the tribal providers in the state. During the onsite discussion with the MCO, though Winnebago Tribal Hospital is not contracted because the facility is not in good standing with CMS, the potential users of this hospital are transferred to the closest hospital based on clinical needs. The members are free to go to any hospital of choice and the MCO covers the services rendered to the member.	
Notice to Members of Provider Termination The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is	**Documents** Policy/procedure Template notice of provider termination	Substantial	This requirement is addressed in the Policy and Procedure for UHC Community and State Provider Initiated Voluntary Termination that states the notice to the member must be provided within 15 calendar days from the receipt of the termination notice from the provider. Actual letters were provided	

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received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.			regarding voluntary termination of providers (as opposed to template letters). Two (2) of these letters were sent 60 days after receipt of the termination notice from the provider and 1 was sent at almost 90 days. **Recommendation** UHCCP should examine the timeliness of the letters that are distributed to members, and ensure that members are notified within 15 days of when the MCO receives the termination notice from the provider. **MCO Response** UHCCP's policy states that notice to the member of a provider termination should be provided within 15 calendar days from the receipt of the termination notice from the provider. UHCCP has identified the root cause of the late notice letters and found that both examples were related to a work routing issue. As a result of the findings, we have updated our work routing processes, and will continue with ongoing monitoring of the processes which will be reported up through to the Compliance Oversight Committee **IPRO Final Findings** No change in review determination.	

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The MCO must provide notice to a member who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change, if the notice is provided in advance.	**Documents** Policy/procedure Template notice of provider termination	Full	This requirement is addressed on page 1 of the Policy and Procedure Nebraska Rider to: UHC and State Provider Initiated Voluntary Termination.	
Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.	**Documents** Policy/procedure	Full	This requirement is addressed on page 2 of the Policy and Procedure Nebraska Rider to: UHC and State Provider Initiated Voluntary Termination.	
Oral Interpretation and Written Translation Services In accordance with 42 CFR 438.10(b)(1), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the State. The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member. This applies to all non- English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Oral and Written Interpretation, which states: "The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member." On page 4 of the Member Handbook it states that language line translations are available for Spanish, Arabic, Vietnamese, French, Burmese & sign language. However, arrangement must be made for oral translation 72 hours before the appointment time and for sign language 2 weeks before the appointment time. Upon discussion with the MCO, in addition to the real-time oral	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately.			interpretation services provided to members, the enrollee may also request a language interpreter to be physically present during an appointment with the provider. The member would have to request this service 72 hours before the appointment and 2 weeks for a sign language interpreter. It was recommended onsite that the MCO add in the Member Handbook the clause "If a member requests for a language interpreter to be present during an appointment the arrangement must be made 72 hours prior to the appointment time and 2 weeks for sign language interpretation".	
Requirements for Member Materials The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC within the policy statement.	
The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 2.	
The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can	**Documents** Policy/procedure Member materials for new members	Full	This requirement is addressed within the Policy and Procedure Member Welcome Material on page 1.	

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find on the website and how to obtain written materials if the member does not have access to the website.				
Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 4 and 20.	
All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 5.	
The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.	**Documents** Policy/procedure Examples of member materials in English and Spanish, such as newsletters and other informational materials	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 6. The MCO's Welcome card is available in English, Spanish, French, Arabic, Vietnamese and Burmese.	
All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 7.	
The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development	

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prominently displayed on all marketing materials, including the cover of all multi-page materials.	Sample marketing materials		and Submission to MLTC under policy 9, and on page 127 of the MCO's Member Handbook.	
All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.	**Documents** Policy/procedure Examples of member materials	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 10, and on page 126 of the Member Handbook.	
All written materials related to MCO enrollment and PCP selection must advise members to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.	**Documents** Policy/procedure Member materials for new members	Full	This requirement is addressed in the Policy and Procedure Marketing Material Development and Submission to MLTC under policy 11, and on page 25 of the Member Handbook.	
Member Handbook The MCO must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. The MCO must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it. At a minimum, the MCO must review and update the member handbook annually The MCO's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the MCO must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they	**Documents** Policy/procedure Member Handbook View website onsite Onsite discussion	Full	This requirement is addressed in the Policy and Procedure Member Handbook Updates and Distribution. The hard copy of the Member Handbook is available in both English and Spanish. The MCO's website also has both the English and Spanish 2018 version of the Member Handbook.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
may receive a new hard copy if they want it, and the process for requesting it.				
At a minimum, the member handbook must include: 1. A table of contents.	**Documents** Member Handbook should address all sub-elements	Full	This requirement is addressed from page 9 to page 11 of the Member Handbook.	
2. A general description of basic features of how MCOs operate and information about the MCO in particular.		Full	This requirement is addressed on page 3 of the Member Handbook.	
3. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.		Full	This requirement is addressed on page 5 of the Member Handbook where the member advocate mailing address for surveys and opinions is specified, and on page 18 (member support) where a description of the member services department, days and hours of operation, toll free number and MCO's major holidays are specified.	
4. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.		Full	This requirement is addressed on page 94 of the Member Handbook.	
5. Member rights/protections and responsibilities.		Full	This requirement is addressed on page 106 of the Member Handbook.	
6. Appropriate and inappropriate behavior when seeing a MCO provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to		Full	This requirement is addressed on pages 12 to 13 of the Member Handbook.	

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another person, could result in loss of the member's Medicaid eligibility and/or legal action.				
7. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.		Full	This requirement is addressed on pages 4 and 19 of the Member Handbook.	
8. A description of the PCP selection process and the PCP's role as coordinator of services.		Full	This requirement is addressed on pages 24 to 25 of the Member Handbook.	
9. The member's right to select a different MCO or change providers within the MCO.		Full	This requirement is addressed on page 25 of the Member Handbook.	
10. Any restrictions on the member's freedom of choice of MCO providers.		Full	This requirement is addressed on page 63 of the Member Handbook.	
11. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.		Full	This requirement is addressed on page 13 of the Member Handbook.	
12. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.		Full	This requirement is addressed on page 62 of the Member Handbook.	
13. Procedures for obtaining benefits, including authorization requirements.		Full	This requirement is addressed on page 38 of the Member Handbook.	
14. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.		Full	This requirement is addressed on page 63 of the Member Handbook.	
15. Information about health education and promotion programs, including chronic care management.		Full	This requirement is addressed on page 86 of the Member Handbook.	

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16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full	This requirement is addressed on page 17 of the Member Handbook.	
17. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".		Full	This requirement is addressed on page 32 of the Member Handbook.	
18. Information about a member's right to a free second opinion and how to obtain it.		Full	This requirement is addressed on page 38 of the Member Handbook.	
19. The extent to which, and how, after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition, emergency services, and post-stabilization services. b. That prior authorization is not required for emergency services. c. The process and procedures for obtaining emergency services, including use of the 911-telephone system. d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.		Full	These requirements are addressed on pages 35, 39, 43 and 73 of the Member Handbook.	
20. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.		Full	This requirement is addressed on page 36 of the Member Handbook.	
21. How to obtain emergency and non-emergency medical transportation.		Full	This requirement is addressed on page 40 and 72 of the Member Handbook.	

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22. Information about the EPSDT program and the importance of children obtaining these services.		Full	This requirement is addressed on pages 27 to 31 and page 62 of the Member Handbook.	
23. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care.		Full	This requirement is addressed on page 87 of the Member Handbook.	
24. Information about member copayments.		Full	This requirement is addressed on page 108 of the Member Handbook.	
25. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.		Full	This requirement is addressed on page 103 of the Member Handbook.	
26. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the MCO's contract with MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection.		Full	This requirement is addressed on page 72 of the Member Handbook.	
27. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.		Full	This requirement is addressed on page 37 of the Member Handbook.	
28. Member grievance, appeal, and state fair hearing procedures and timeframes, as follows: a. For grievances and appeals:		Full	These requirements are all addressed from page 108 to page 113 of the Member Handbook.	

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i. Definitions of a grievance and an appeal. ii. The right to file a grievance or appeal. iii. The requirements and timeframes for filing a grievance or appeal. iv.. The availability of assistance in the filing process. v. The toll-free number(s) the member can use to file a grievance or an appeal by telephone. vi. The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.				
b. For state fair hearing: 1. Definition of a state fair hearing. 2. The right to request a hearing. 3. The requirements and timeframes for requesting a hearing. 4. The availability of assistance to request a fair hearing. 5. The rules on representation at a hearing.		Full	These requirements are all addressed on page 113 of the Member Handbook.	

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6. The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.				
29. A description of advance directives that includes: a. The State's and MCO's policies about advance directives. b. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.		Full	These requirements are all addressed on pages 99 and 106 of the Member Handbook.	
30. Information about how members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements.		Full	This requirement is addressed on page 101 of the Member Handbook.	
31. How a member may report suspected provider fraud and abuse, including but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose.		Full	This requirement is addressed on page 102 of the Member Handbook.	
32. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the MCO.		Full	These requirements are all addressed on page 6 and page 37 of the Member Handbook.	

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b. The MCO's physician incentive plan (42 CFR 438.6(h)). c. The MCO's service utilization policies. d. How to report alleged marketing violations to MLTC. e. Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.				
33. A minimum of once a year, the MCO must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.		Full	This requirement is addressed in the Policy and Procedure for Annual Notice to Members.	
Other Member Notifications The MCO must also provide the following information to each member: A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.	**Documents** Policy/procedure Evidence of member notification	Full	This requirement is addressed in the Policy and Procedure Annual Notice to Members, which also included the Annual Notice Letter template. The MCO provided actual letters sent out to Members dates September 01, 2017.	
A minimum of annually, the MCO will inform all members of their right to request the following information. 1. An updated member handbook, at no cost to the member.	**Documents** Policy/procedure Evidence of member notification	Full	This requirement is addressed in the Policy and Procedure Annual Notice to Members, as well as in the Annual Notice Letter template.	

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2. An updated provider directory, at no cost to the member.				
Member Newsletter The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to: 1. Educational information on chronic illnesses and ways to self-manage care. 2. Behavioral health information. 3. Reminders of flu shots and other prevention measures at appropriate times. 4. Medicare Part D issues. 5. Cultural competency issues. 6. Tobacco cessation information and programs. 7. HIV/AIDS testing for pregnant women. 8. Other topics as requested by MLTC.	**Documents** Policy/procedure copies of member newsletters issued during the review period	Full	This requirement was evidenced within the member newsletters the MCO provided for fall 2017 and spring 2018.	
Provider Directory for Members The MCO must develop and maintain a provider directory for its members in three (3) formats: 1. A hard copy directory, when requested, for members, potential members, and the enrollment broker. 2. A web-based, searchable, online directory for members, potential members, and the general public.	**Documents** Policy/procedure Provider directory View website onsite	Full	These requirements are addressed in the Policies and Procedures for: Provider Directory Creation and Distribution; Rally – Online Directory. An actual copy of the provider directory was made available by the MCO. The MCO's website also provides a link for members to search providers.	

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3. An electronic file of the directory to be submitted and updated weekly to MLTC or its designee, and the enrollment broker.				
The hard copy directory for members must be updated a minimum of monthly. The web-based version must be updated in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.	**Documents** Policy/procedure	Full	This requirement is addressed in the Policy and Procedure for Provider Directory Creation and Distribution.	
In accordance with 42 CFR 438.10(f)(6), the provider directory must include, but not be limited to: 1. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers who/that are not accepting new patients must be identified. 2. Hours of operation, including identification of providers with non-traditional hours (before 8 am, after 5 pm, or any weekend hours).	**Documents** Policy/procedure Provider directory View website onsite	Full	The requirement is addressed in the Policy and Procedure for Provider Directory Creation and Distribution. Further, all information is noted within the hard copy of the provider directory.	
Member Website The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed in the Policy and Procedure for Member Portal. The MCO's website also has on its home page an information section where current news about the Medicaid program is available.	

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questions and comments to the MCO and receive responses). The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. Use of proprietary items that would require use of a specific browser or other interface is not allowed.				
The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members: 1. The most recent version of the member handbook. 2. Telephone contact information for the MCO, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number.	**Documents** Policy/procedure View website onsite	Full	These requirements are all addressed in the Policy and Procedure for Member Portal. All requirements are also evidenced on the MCO's website.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
3. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the MCO network. 4. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment. 5. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. 6. Information about how to file grievances and appeals.				
Advance Directives The MCO must maintain written policies and procedures for advance directives. The MCO must provide written information to all adult members with respect to: 1. Their rights under applicable law. 2. The MCO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. The MCO is prohibited from conditioning the provision of care or otherwise discriminating	**Documents** Policy/procedure	Full	These requirements are all addressed in the Policy and Procedure for Advance Directives, and in the MCO's Member Handbook.	

Member Services and Education				
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against an individual based on whether or not the individual has executed an advance directive. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health. Any written information on advance directives must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of a change.				

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Quality Management The MCO must include QM processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The MCO's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system as a result of this RFP. The MCO will be provided with the final Quality Strategy when it is approved by CMS. The MCO must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities.				
The MCO's QM program must include: 1. A quality assurance and performance improvement (QAPI) program. 2. Performance improvement projects (PIPs). 3. Quality performance measurement and evaluation. 4. Member and provider surveys.	**Documents** QM Program Description	Full	These elements are addressed within the Quality Improvement Program Description.	

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5. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program.				
The MCO must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.	**Documents** QM Program Description Corporate organizational chart QM department organizational chart	Full	This requirement is addressed within the QI Program Description, and in the org chart provided by UHCCP. Tracking and trending of issues is evidenced within the QAPIC meeting minutes.	
Quality Management Deliverables The MCO must submit the following QM deliverables to MLTC: Description and composition of the QAPI Committee (QAPIC).	**Documents** QM Program Description	Full	UHCCP's Quality Management Committee (QMC) is described within their QI Program Description (note: committee name changed from QAPIC to QMC. There are two instances where QAPIC is still being referred to; for consistency, these references should be removed and replaced with "QMC").	
A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes. QM Program Description due date: 30 calendar days following 12th month of contract year	**Documents** QM Program Description	Full	This requirement is addressed within the QI Program Description.	
A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QM activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to: 1. Data collection and analysis.	**Documents** QM work plan	Full	This requirement is addressed within the QM work plan.	

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2. Evaluation and reporting of findings. 3. Implementation of improvement actions, where applicable. 4. Individual accountability for each activity. QM work plan due date: 30 calendar days following 12th month of contract year				
Procedures for remedial action for deficiencies that are identified.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in Policy QM 100 Remedial and Corrective Action for Quality Improvement Work Plan.	
Specific types of problems requiring corrective action.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in Policy QM 100 Remedial and Corrective Action for Quality Improvement Work Plan.	
Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in Policy QM 100 Remedial and Corrective Action for Quality.	
Procedures for provider review and feedback about results.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QI Program Description, and in Policy QM 100 Remedial and Corrective Action for Quality.	
Annual QM evaluation that includes: 1. Description of completed and ongoing QM activities. 2. Identified issues, including tracking of issues over time. 3. Analysis of and tracking progress about implementation of QM goals and the principles of care, as appropriate. Measurement of and compliance	**Documents** QM Evaluation Onsite discussion	Full	This requirement is addressed in UHCCP's 2017 QI Program Evaluation. Evidence of appropriate industry-recognized methodologies for data analysis is found in the QI Program Evaluation that is being submitted to MLTC for approval. Clinical Medical Record Review activities yielded some important findings and corresponding improvement opportunities	

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with these principles must be promoted and enforced through the following strategies, at a minimum: a. Use of QM findings to improve practices at the MCO and subcontractor levels. b. Timely reporting of findings and improvement actions taken and their relative effectiveness. c. Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website. d. Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions. e. An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program. QM Evaluation due date: 30 calendar days following 12th month of contract year			(advance directive in member records, demographic and preferred language, etc.) The work that the Clinical Practice Consultants (CPCs) are doing appears to be very effective in closing gaps in patient care, as demonstrated in UHCCP's QI Program Evaluation. CPCs work directly with the MCO's priority offices and FQHCs in order to facilitate gap closure; successes to-date include improvements in the rates of well child visits, lead screening, assessment of weight management in adolescents, immunizations for adolescents, and diabetes care. Additionally, the MCO has attempted to address prenatal/postpartum care via their Baby Block program, Healthy First Steps, and baby showers, however acknowledge that there is still opportunity for improvement in prenatal/postpartum care outcome measures. Lastly, the MCO began piloting their MyMoney program, to incentivize members to receive preventive screenings and care.	

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Procedures assessing the quality and appropriateness of care furnished to members with SHCNs. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.	**Documents** QM Program Description Policy/procedure	Full	This is addressed in UHCCP's Policy Assessment of the Quality and Appropriateness of Care for Members with Special Health Care Needs. The CAHPS Child survey of children with chronic conditions assesses aspects of member satisfaction for children with special health care needs.	
QAPI Program The MCO's QAPI program, at a minimum, must comply with State and Federal requirements (including 42CRF 438.204) and UM program requirements described in 42 CFR 456. The QAPI program must: Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC.	**Documents** QM Program Description	Full	This requirement is addressed within the QI Program Description.	
At a minimum, assess the quality and appropriateness of care furnished to members.	**Documents** QM Program Description	Full	This requirement is addressed within the QI Program Evaluation on page 18. This requirement is also addressed throughout the QI Program Description, with reference made to monitoring and improving quality of care and review potential substandard or inappropriate care.	
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.	**Documents** QM Program Description	Full	This requirement was addressed onsite, with evidence provided regarding state Medicaid ID loading and maintenance guidelines.	

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Maintain a health information system that can support the QAPI program. The MCO's information system 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 MCO and MLTC.	**Documents** QM Program Description	Full	This requirement is addressed within the QI Program Description, which states that the MCO will "Develop and maintain reporting systems that provide appropriate information for meeting the requirements of external regulatory and accrediting entities" (page 7). The MCO may consider incorporating into the QM Program Description, information regarding CM systems/UM systems (over and under-utilization for instance) and how health info are stored/maintained and utilized to support QAPI Program.	
Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually.	**Documents** Evidence of providing information about the QAPI program to members and providers	Full	Information for how the QAPI Program is communicated to providers is found in the Provider Manual. Communication related to members is found in the Member Handbook. Further, the Practice Matters Newsletters provide examples of UHCCP's QI initiatives throughout the year (e.g., case managers helping members with complex needs and expanding their Healthy First Steps Program). Information related to how UHCCP is progressing towards meeting their goals annually can be found on their website.	
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 MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of,	**Documents** Description of methods used to solicit feedback and recommendations Onsite discussion	Full	This requirement is addressed within the QI Program Description, and the QAPIC and QMC meeting minutes that were provided. QAPIC and QMC meeting minutes demonstrate the process wherein stakeholders provide feedback, which is followed-up with at each Committee meeting.	

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MLTC, members, family members, providers, and other stakeholders.				
Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCO and any additional QM reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.	**Documents** QM Program Description	Full	This requirement is addressed in the QI Program Description, and per evidence obtained onsite (documentation, subcontractor monitoring, and staff interviews).	
QAPIC The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes. The MCO must form a QAPIC no later than one month following the contract's start date. The MCO's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.	**Documents** QM Program Description Description of QAPIC	Full	This requirement is addressed within the QI Program Description (Member Advisory Committee, and Clinical and Provider Advisory Committee descriptions).	
The MCO must include, at a minimum, the following as members of the committee: 1. The MCO's QM Coordinator. 2. The MCO's Performance and Quality Improvement Coordinator. 3. The MCO's Medical Management Coordinator. 4. The MCO's Member Services Manager.	**Documents** QAPIC membership	Full	This requirement is addressed; although the Program Description does not reference QM coordinator or Provider Services Manager, and children/youth are not specified (only "Medicaid members or family member/guardian" is stated), the QAPIC/QMC meeting minutes provide evidence that members of the committee include the individuals/groups outlined in the requirements. Since QAPIC membership is appropriately demonstrated within the minutes, this requirement is fully addressed. It	

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5. The MCO's Provider Services Manager. 6. Family members/guardians of children or youth who are Medicaid members. 7. Adult Medicaid members. 8. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.			is recommended that the MCO update the QI Program Description to correspond better to the membership list detailed within the requirements.	
The MCO's QAPIC must: 1. Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC. 2. Review the Cultural Competency Plan. 3. Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify. 4. Establish annual performance targets. 5. Review and approve all member and provider surveys prior to their submission to MLTC. 6. Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries.	**Documents** QM Program Description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the QI Program Description, which details the role and responsibilities of the QAPIC. QAPIC/QMC meeting minutes provide evidence that the MCO is continuously evaluating their various QI programs as well as their progress in achieving QI goals. These minutes also contain evidence that cultural competency reports are reviewed, as well as committee work plans (which are then integrated within the QI work plan).	

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7. Provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization. 8. Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.				
Additional required committees must include: 1. Clinical Advisory Committee. 2. Corporate Compliance Committee. 3. Provider Advisory Committee. 4. Utilization Management Committee. 5. The additional required committees must report, on a minimum of a quarterly basis, to the QAPIC. The QAPIC must monitor performance as part of its annual QAPI Work Plan and Program Evaluation.	**Documents** Committee descriptions List of membership for each committee QM work plan QM Evaluation	Full	Each committee is represented within the QI Program Description. The QM Evaluation includes the monitoring of activities of each of these committees.	
Data Collection The MCO must collect performance data and conduct data analysis with the goal of improving members'	**Reports** Reports of state-required performance measures	Full	Performance Improvement Project (PIP) measures are well-established, per evidence provided within the finalized project proposals.	

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quality of care. The MCO must document and report to the State its results on performance measures chosen by MLTC to improve quality of care and members' health outcomes.			Performance measures are not due until June 2018. The previous year's performance measures are outside of the time period for this review. UHCCP details their monitoring and analysis plan via Policy QM 101 Performance Measures Monitoring and Analysis.	
Data analysis must consider the MCO's previous year's performance, 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 MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO must ensure that data received from providers is accurate and complete by: 1. Verifying the accuracy and timeliness of reported data. 2. Screening the data for completeness, logicalness, and consistency. 3. Collecting service information using MLTC-developed templates. A quarterly report from the Quality Oversight Committee containing an activity summary as is due	**Documents** Process for verifying the accuracy and completeness of provider and vendor reported data Process for screening data for completeness, logic and consistency Evidence of collecting service utilization data using MLTC-developed templates **Reports** Sample data analysis produced by MCO providing information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals	Full	UHCCP submitted reports demonstrating timely submission to MLTC. Data analysis provides information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals.	

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to MLTC 45 calendar days following the most recent quarter				
The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing 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 MCO.	**Documents** Evidence of timely and accurate reporting of encounter data to MLTC **Reports** Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up	Full	This requirement is addressed in POL.3627243 HEDIS Data Auditing (Internal & External). PIP data have been collected and reported in a manner consistent with MLTC expectations throughout the review period. Evidence of timely and accurate reporting of encounter data was submitted to MLTC within the appropriate timeframes, according to Attachment 38. Critical incident reporting has taken place monthly since the revisions to Attachment 38.	
Quality Performance Measurement and Evaluation The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC. HEDIS results due date: June 30 CHIPRA quality measures and Adult core measures due date: 45 calendar days following 12th month of contract year	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final audit report and IDSS rates CAHPS report Onsite discussion	Full	UHCCP's PIP proposals were submitted in December 2017, in anticipation of the project start date of January 1, 2018. The annual reports associated with these PIPs (Tdap in pregnant women, 17p initiation, and follow-up after an ED visit for mental health/substance use disorder) will be expected within the 30 calendar days following the twelfth month of the contract year, per Attachment 38. UHCCP submitted reports for the Adult CAHPS survey report, Child CAHPS survey with the Children with Chronic Conditions component. The data contained within these reports were outside of the September 1, 2017 – March 15, 2018 time period. UHCCP has hired a clinical practice consultant (CPC) dedicated to women's health education, who is focusing on Ob/Gyn practices. This individual will also educate other CPCs, and	

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Attachment 7: Adult Core Measures 1. Cervical Cancer Screening (CCS) 2. Chlamydia Screening in Women (CHL) 3. Flu Vaccinations for Adults Age 18 and Older (FVA) 4. Screening for Clinical Depression and Follow-Up Plan (CDF) 5. Breast Cancer Screening (BCS) 6. Adult Body Mass Index Assessment (ABA) 7. PC-01: Elective Delivery (PC01) 8. PC-03: Antenatal Steroids (PC03) 9. Prenatal & Postpartum Care: Postpartum Care Rate (PPC) 10. Initiation and Engagement of Alcohol and Other 11. Drug Dependence Treatment (IET) 12. Medical Assistance with Smoking and Tobacco Use Cessation (MSC) 13. Antidepressant Medication Management (AMM) Follow-Up After Hospitalization for Mental Illness (FUH) 14. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA) 15. Controlling High Blood Pressure (CBP) 16. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C) 17. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)* 18. PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01) 19. PQI 08: Heart Failure Admission Rate (PQI08) 20. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05) 21. PQI 15: Asthma in Younger Adults Admission Rate (PQI15)			promote women's health education within the western/rural region. Measures demonstrating decreases or gaps from goal (according to HEDIS 2017): 1. Antidepressant Medication Management-Effective Acute Phase Treatment 2. Antidepressant Medication Management-Effective Continuation Phase Treatment 3. Appropriate Treatment for Children With Upper Respiratory Infection 4. Breast Cancer Screening 5. Comprehensive Diabetes Care: a. Eye Examination b. B/P Control < 140/90 c Medical Attention for Nephropathy d. HbA1c Control (< 8%) 6. Controlling High Blood Pressure 7. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 8. Human Papilloma Vaccine for Female Adolescents 9. Immunizations for Adolescents (Combo 1) 10. Medication Management for People With Asthma (Medication Compliance 75% Rate only) 11. Pharmacotherapy Management of COPD Exacerbation-Bronchodilator 12. Use of Imaging Studies for Low Back Pain Childhood Immunization Status (Combo 2) UHCCP identified various barriers associated with sub-optimal performance of rates, and corresponding interventions, including direct	

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22. Plan All-Cause Readmissions (PCR) 23. HIV Viral Load Suppression (HVL) 24. Annual Monitoring for Patients on Persistent Medications (MPM) 25. Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR) 26. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA) <u>Child Core Measures</u> 1. Child and Adolescents' Access to Primary Care Practitioners (CAP) 2. Chlamydia Screening in Women (CHL) 3. Childhood Immunization Status (CIS) 4. Well-Child Visits in the First 15 Months of Life (W15) 5. Immunizations for Adolescents (IMA) 6. Developmental Screening in the First Three Years of Life (DEV) 7. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) 8. Human Papillomavirus Vaccine for Female Adolescents (HPV) 9. Adolescent Well-Care Visit (AWC) 10. Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI) 11. PC-02: Cesarean Section (PC02) 12. Live Births Weighing Less Than 2,500 Grams (LBW) 13. Frequency of Ongoing Prenatal Care (FPC) 14. Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)			member and provider outreach, as well as postcards, mailings, and newsletters. To further address barriers/gaps in care, UHCCP's Member and Provider Customer Service teams were transitioned to their Omaha location, to centralize and ensure collaboration and oversight of activities. UHCCP's EPSDT coordinator has identified an opportunity to close gaps among the siblings of children she is reaching out to for targeted intervention. The MCO created a Customer Service Gap Closure Report, which details the activities of the customer service representative in addressing members' gaps in care. When the customer service representative has a member on the phone, they will receive a 'pop-up' of any needed services for the member. During the call, they remind the member of the needed services, and if the member requires help schedule an appointment or transportation, the customer service representative will stay on the line and assist the member. The customer service representative will then document specific measures or gaps in care they discussed with the member. These gaps are then communicated with providers by the CPCs, who take patient care opportunity reports out to the primary care providers monthly or quarterly based on provider request. A new enhancement is available on LINK that allows providers to pull their own patient opportunity care reports more frequently, if they wish to do so.	

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15. Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) 16. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) 17. Follow-Up After Hospitalization for Mental Illness (FUH) 18. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)* 19. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC) 20. Medication Management for People with Asthma (MMA) 21. Ambulatory Care – Emergency Department (ED) Visits (AMB) 22. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC) <u>HEDIS Measures</u> 1. Comprehensive Diabetes Care 2. Medication Management for People with Asthma (Adults) 3. Lead Screening in Children 4. Appropriate Testing for Children with Pharyngitis 5. Race/Ethnicity Diversity of Membership 6. Appropriate Treatment for Children with Upper Respiratory Infection (URI) 7. Use of Spirometry Testing in the Assessment and Diagnosis of COPD 8. Pharmacotherapy Management of COPD Exacerbation				

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9. Use of Appropriate Medications for People with Asthma 10. Annual Monitoring for Patients with Persistent Medications 11. Adults' Access to Preventative/Ambulatory Health Services 12. Antibiotic Utilization 13. Frequency of Ongoing Prenatal Care 14. Timeliness of Prenatal Care				
MLTC may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by 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 will be based on HEDIS, external quality review (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 on request with its methodology for calculating performance measures.	**Reports** HEDIS final audit report and IDSS rates	Not Applicable	HEDIS performance measures were not evaluated within the timeframe associated with this year's compliance review. Data collection processes, however, are well documented within Policy QM 101 HEDIS rate monitoring and analysis, and Policy HEDIS data Auditing (Internal and External).	
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 and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.	**Reports** HEDIS final audit report and IDSS rates Trended performance measure results	Not Applicable	HEDIS measures were not reported for the measurement period being reviewed. Data collection processes, however, are well documented within Policy QM 101 HEDIS rate monitoring and analysis, and Policy HEDIS data Auditing (Internal and External). Further, UHCCP's QI Program provides evidence that the MCO trends performance and identifies barriers to achieving their goals.	

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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 QAPI Committee and approved by MLTC.	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final IDSS rates Review of website Onsite discussion	Full	UHCCP provided reports for each of the PIPs that were submitted in December 2017 for the January 2018 implementation. These PIPs were selected based on state priorities, and areas where opportunities were identified. HEDIS FUM and FUA measures are being used to evaluate the behavioral health PIP (Follow-up after an ED Visit for mental health illness/substance use disorder). The PIPs are reported to and validated by IPRO annually, and discussed monthly at the Quality Improvement Committee meetings, and quarterly at the Quality Management Committee meetings with the other MCOs and MLTC.	
Any outcomes and performance measure 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.	**Reports** HEDIS final audit report and IDSS rates Methodology for non-HEDIS performance measure reporting Trended performance measure results and comparison to national benchmarks including f/u actions taken	Full	This requirement pertaining to sampling is addressed in policy HEDIS Data Auditing (Internal & External). Performance measures submitted have corresponding benchmark and past-performance rates for comparison purposes.	
Performance Improvement Projects The MCO must conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.	**Reports** PIP proposals and status reports	Full	UHCCP provided the proposals for each of the PIPs that were submitted in December 2017 for January 2018 intervention implementation. These PIPs were selected based on state priorities, and areas where opportunities were identified. HEDIS FUM and FUA measures are being used to evaluate the behavioral health PIP (Follow-up after an ED Visit for mental health illness/substance use disorder). The PIPs are reported to and validated by IPRO annually, and discussed monthly at the Quality	

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			Improvement Committee meetings, and quarterly at the Quality Management Committee meetings with the other MCOs and MLTC.	
The MCO must participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC.	**Reports** PIP proposals and status reports	Full	This required is addressed; each MCO collaborates on all three PIP topics identified by MLTC.	
PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program Evaluation. PIPs must comply with CMS requirements, including: 1. A clear study topic and question as determined or approved by MLTC. 2. Clear, defined, and measurable goals and objectives that the MCO can achieve in each year of the project. 3. A study population. 4. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate. 5. The methodology for evaluation of findings from data collection.	**Documents** QM Program Description QM work plan QM Evaluation	Full	PIPs are outlined within the QI Program Description, the QM Work Plan and the QM Evaluation. Each of the PIP proposals that were submitted for review in December contained each of the necessary CMS requirements. IPRO will continue to monitor PIP activities, and validate meaningful data collection and intervention development in response to barriers, evaluation of intervention tracking measures, and potential for sustainability of the project.	

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6. Implementation of system interventions to achieve quality improvement. 7. A methodology for the evaluation of the effectiveness of the chosen interventions. 8. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable. 9. Planning and initiation of activities for increasing and sustaining improvement.				
The MCO 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.	**Documents** QM Program Description QM work plan QM Evaluation	Full	The status of PIPs is appropriately included in the QI Program Evaluation. This includes the aim statements and goals of each of the projects initiated in January 2018. Incorporation of PIP results into the QI Program Description is not applicable for this review period. The QI Work Plan includes information related to PIPs, in terms of ensuring PIPs are in a state of readiness with quarterly updates in the state-mandated template.	
Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program.	**Reports** PIP proposals and status reports	Full	The 2018 PIPs are two years in duration, allowing for enough time to pilot interventions designed in response to barrier analysis, gather data to evaluate the success of these interventions, modify accordingly, and then roll out more broadly.	
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.	Onsite discussion	Not Applicable	UHCCP confirmed that no additional performance measures or PIPs have been requested by CMS.	

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Member Satisfaction Surveys The MCO must contract with a vendor that is certified by NCQA to perform CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items.	**Documents** Identity of CAHPS vendor **Reports** CAHPS adult and child survey reports Onsite discussion	Full	UHCCP contracted with DSS, an NCQA certified vendor to administer the CAHPS Adult and Child CCC surveys.	
The MCO must use the most current version of CAHPS for Medicaid enrollees. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports to MLTC to fulfill the CHIPRA requirement.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	UHCCP submitted CAHPS adult and child survey reports. For the child survey component, the MCO separated the sample of Medicaid and CHIP populations.	
Samples of members 18 years of age and older and caregivers/family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers/family members based on the type of question asked.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement was addressed within the reports DSS prepared on behalf of UHCCP.	
Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. MLTC reserves the right to make CAHPS member survey results public.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement was addressed within the reports DSS prepared on behalf of UHCCP.	
Survey results and descriptions of the survey process must be reported to MLTC separately for each	**Reports** CAHPS adult and child survey reports	Full	This requirement was addressed within the reports DSS prepared on behalf of UHCCP.	

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required CAHPS survey. Upon administration of the CAHPS Child surveys, results for Medicaid children and CHIP children must be reported separately. CAHPS reports due date: 30 calendar days following 12th month of contract year	Onsite discussion			
Provider Satisfaction Surveys The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes, including medical reviews and support for PCMH implementation.	**Documents** Provider satisfaction survey tool Onsite discussion	Full	This requirement is addressed, per evidence provided within the Provider Survey Tool, letter, and survey results. Providers were emailed or faxed the survey four times beginning September 6, 2017. Surveys returned from providers were collected through October 13, 2017.	
The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.	**Documents** Provider satisfaction survey tool and methodology Onsite discussion	Full	This requirement is addressed in Provider Survey Results Annual Report (calendar year 2017). MLTC approved Provider Survey Tool prior to administration. The final sample size included 1,335 providers that consisted of physicians, behavioral health, ancillary and facility providers. There were 72 responses received for UnitedHealthcare Community Plan of Nebraska. This represents a 5.4% percent response rate and an increase in participation from 2016.	
The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities	**Reports** Provider satisfaction survey results including f/u actions taken	Full	This requirement is addressed, per evidence contained within the Provider Survey Results Annual Report.	

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for improvement and action plans derived from survey results. Provider satisfaction survey report due date: 30 calendar days following 12th month of contract year			The MCO identified the following areas for improvement: Prior Authorization Process Relationship with UHCCP Appeals Process Care Management Although there were increases in each of these categories from 2016, they scored lowest in satisfaction scores for 2017 compared with other categories. UHCCP identified three drivers of provider satisfaction: 1. Claims and appeals (timeliness and accuracy, along with communication of appeal outcomes) 2. Support services 3. Easy to work with In response to each of these drivers, the MCO developed action plans (centered on operational consistency across work units, to improve performance related to these drivers). The following initiatives have been implemented: 1) established targeted trust point efforts to expand the use of the Provider Experience index, targeted focus on prior authorization, improve strategy for communication and coordination on provider pain points; and 2) developed local market core account targets as part of advocate reinvigoration and enhanced provider engagement strategy.	

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Member Advisory Committee To promote a collaborative effort to enhance the MCO's patient-centered service delivery system, the MCO must establish a Member Advisory Committee that is accountable to the MCO's governing body. Its purpose is to provide input and advice regarding the MCO's program and policies.	**Documents** Member Advisory Committee description	Full	This requirement is addressed in the Member Advisory Committee Annual Plan.	
The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.	**Documents** Member Advisory Committee description Member Advisory Committee membership	Full	This requirement is addressed within the Member Advisory Committee Annual Plan on pages 3 and 4. The MCO also submitted a Member Advisory Committee roster that further supports this requirement being addressed.	
At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QM/quality improvement activities; program monitoring and evaluation; and, member, family, and provider education.	**Documents** Member Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed within the Member Advisory Committee Annual Plan on page 4.	
The MCO must provide an orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities.	**Documents** Evidence of orientation and training including training materials	Full	This requirement is addressed within the Member Advisory Committee Annual Plan on page 2.	
The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This Plan must be submitted to MLTC for approval a	**Documents** Member Advisory Committee Plan	Full	UHCCP submitted their Member Advisory Committee Annual Plan that meets this requirement.	

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minimum of 60 calendar days before the contract start date and annually thereafter.				
The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This language (committee must meet a minimum of quarterly) is addressed within the Member Advisory Committee Annual Plan. Meeting minutes were submitted for each meeting that took place monthly in Q4 of 2017, and quarterly beginning 2018. Discussion appears meaningful, where member concerns and questions are being addressed and followed-up on with UHCCP staff.	
The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members, and information about Committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in Attachment 38 – Revised Reporting Requirements. Semi-annual reports due date: June 30 and Dec 31	**Documents** Semi-annual reports submitted during the review period	Full	This requirement is addressed within Member Advisory Committee Report, submitted in June and December 2017.	
Clinical Advisory Committee The MCO must develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or	**Documents** Clinical Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed within the CAC description located within the QI Program Description, and in the meeting minutes/agendas submitted for the review period.	

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substance use disorder treatment for adults, children, and adolescents in the State.				
The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice guidelines, and utilization management criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is outlined in the QI Program Description, and evidenced within the meeting minutes/agendas submitted for the Clinical and Provider Advisory Committee (CPAC).	
The committee must include members who care for children, adolescents and adults in the State across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations and represent pharmacists, physical health providers, and behavioral health providers.	**Documents** Clinical Advisory Committee membership	Full	This requirement is evidenced within the CPAC meeting minutes roster.	
The committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed/approved by the Committee prior to adoption by the MCO.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is evidenced within the CPAC meeting minutes.	
The committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed. During the review period, the CPAC had met quarterly.	
External Quality Review The MCO 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. The EQR is conducted by MLTC's contracted external quality review organization (EQRO) or other designee. The EQR will include, but is	Onsite discussion	Full	All EQR activities were discussed within the context of the compliance review, which took place May 14, 2018 – May 15, 2018.	

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not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.				
The MCO must provide the necessary information required for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.	Onsite discussion	Full	UHCCP provided all needed amenities and had staff readily available for questions and interviews.	

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Utilization Management **General Requirements** The MCO'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 MCO'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 MCO 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.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the MCO's UM Program under section V Policy Provisions on page 2, in the operational policy UCSMM.02.12 Performance Assessment and Incentives, and in the UM Program Description under section XX. Financial Compensation on page 30.	
UM Program Description The MCO must have a written UM Program description that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum: Criteria and procedures for the evaluation of medical necessity of medical services for members.	**Documents** UM Program Description should address all sub-elements	Full	This requirement is addressed throughout the UM Program Description.	
Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.		Full	This requirement is addressed in the UM Program Description under Section E XII Appeals on page 27 and in UCSMM.07.12 Appeal Process and Record Documentation on pages 1 through 3.	

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Mechanisms to detect and document over- and under-utilization of medical services.		Full	This requirement is addressed in the UM Program Description on pages 7, 23, and 29. This requirement is also addressed in the MCO UM Program under Section V Policy Provisions on pages 3–4 and in the Drug Utilization Review Policy on page 3. The Provider Profiling and Monitoring of Over & Under Utilization Policy also fulfills this requirement.	
Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.		Full	This requirement is addressed in the UM Program Description on pages 19–20 and in the Clinical Practice Guidelines Policy and Procedure on page 1 under Section V.A. Development and Adoption of Practice Guidelines.	
Availability of UM criteria to providers.		Full	This requirement is addressed in the UM Program Description on pages 25–26 and in the Clinical Practice Guidelines Policy and Procedure on pages 1–2 under Section V.B. Dissemination of Guidelines.	
Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.		Full	This requirement is addressed in the UM Program Description on pages 7, 17, and 27, and in the MCO's UM Program on page 2.	
Availability of physician reviewers to discuss determinations by telephone with physicians who request them.		Full	The operational policy UCSMM.06.15 Peer Clinical Review addresses peer-to-peer discussion of review determinations on pages 2–3. This requirement is also addressed in the Utilization Management of Behavioral Health Benefits Policy on page 7.	
Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.		Full	This requirement is addressed in the UM Program Description on pages 15–16.	

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A process and procedures to address disparities in health care.		Full	This requirement was not addressed in the UM Program Description submitted by the MCO. Onsite, however, the MCO provided the Efforts to Reduce Healthcare Disparities document (dated February 20, 2018), which is a part of the UM Program that is in the process of being developed and approved. In order to bolster the MCO's efforts to reduce disparities in healthcare, they may consider adding explicit language regarding potential vulnerable populations and potential disparities to be targeted, as per CMS Disparities Action Plan. The document provided onsite does include vulnerable populations, such as Native Americans, age and gender minorities as well as cultural and language minorities.	
A process for identifying and analyzing clinical issues by appropriate clinicians and, when necessary, developing corrective actions to improve services.		Full	This requirement is addressed in the UM Program Description on pages 6, 7, 11, and 29.	
A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR.		Full	This requirement is addressed in the UM Program Description on pages 13–14, in the Drug Utilization Review Policy, and in the Utilization Management of Behavioral Health Benefits Policy.	
Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List and other State publications.		Full	This requirement is addressed in the UM Program Description on pages 16–17, the Pharmacy Program Policy, and in the PDL Change Notice Policy on pages 2–3.	

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A process for providing prescribers with members' drug utilization data obtained from MLTC and the Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must: 1. Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing. 2. Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.		Full	This requirement is addressed in the UM Program Description on pages 16–17 and 29. This requirement is also addressed in the Drug Utilization Review Policy on pages 3–5 and in the Pharmaceutical Management Systems Drug Utilization Review Board Policy on page 2.	
A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 30 calendar days after its completion.		Full	The annual evaluation of the UM Program is described in the UM Program Description on page 30 and in the MCO's UM Program Policy on pages 3 and 5. The requirement that states that the UM Program evaluation must be submitted to MLTC no later than 30 calendar days after its completion is included in the contract under Reporting Requirements. Onsite, the MCO indicated that the UM Program Evaluation will be submitted within 30 days of completion. The MCO may want to consider including the verbiage "no later than 30 calendar days after its completion" explicitly in the UM Program Description.	
Practice Guidelines The MCO must develop practice guidelines that:	**Documents** Policy/procedure List of practice guidelines developed/adopted by MCO Examples of practice guidelines	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 1 and in the Pharmaceutical Management Systems – Pharmacy and Therapeutics Committee Policy on page 4.	

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Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.			Examples of practice guidelines accessible online at www.provider.express.com provide evidence for this requirement.	
Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 1. Practice guidelines accessible online at www.providerexpress.com provide evidence for this requirement. Onsite, the MCO detailed the processes that allow them to develop and assess their guidelines in the context of special needs. The MCO reported that the Policy Committee includes healthcare professionals and specialists who develop evidence-based practice guidelines and review these for updates regularly, including for special needs.	
Are adopted in consultation with participating health care professionals.	**Documents** Policy/procedure Evidence of participation of health care professionals	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 1. The participation of contracted healthcare professionals was evidenced in minutes of the National Medical Care Management Committee meetings (example: January 2018 meeting minutes) and in the minutes of the Medical Technology Assessment Committee meetings (monthly meeting minutes September 2017–January 2018).	
Are reviewed and updated a minimum of annually, as appropriate.	**Documents** Policy/procedure	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 1. This requirement is also addressed by	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			the Behavioral Health Clinical Review Criteria Policy on page 1 and in the Optum Clinical Criteria Policy on page 2, item 2.4.	
Are disseminated, by the MCO, to all affected providers and, on request, to members and enrollees.	**Documents** Policy/procedure Evidence of dissemination to providers Member Handbook	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 1. Practice guidelines are made available on the MCO's website. In addition, members are made aware of these guidelines in the Member Handbook, which includes a description on how members can obtain a paper copy, as well as instructions on how they can view these guidelines on the MCO's website on page 104.	
Are posted to the MCO's website.	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 2. The MCO's Providerexpress.com website has operational links to guidelines under Clinical Resources/Guidelines and Policies. The clinical guidelines are available and easily accessible in the ProviderExpress.com website under Clinical Resources/Guidelines and Policies.	
Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply.	**Documents** Policy/procedure	Full	This requirement is addressed in the Clinical Practice Guidelines Policy and Procedure on page 2. This requirement is also addressed in the Initial Clinical Review Policy, where qualifications of UM staff and measures taken for consistent decision making are detailed. Policies and evidence of ongoing inter-rater reliability monitoring also supports this	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			requirement (Pharmacist Inter-Rater Reliability of Pharmacy Coverage Reviews, Physician Inter-Rater Reliability of Pharmacy Coverage Reviews, UM09_UHC_NE_EQRO_2017_ MCG_AC_IRR).	
The MCO must provide affected network providers with technical assistance and other resources to implement the practice guidelines.	**Documents** Policy/procedure Evidence of offering/providing technical assistance and other resources	Full	The MCOs website lists network management contact information for Nebraska under Contact Us/Network Management Contacts/Nebraska. An address, phone number, and a fax number are provided. The MCO's website also includes the National Network Manual under Clinical Resources. The MCO submitted their Spring Provider Forum presentation, which includes website and communication information for providers for technical and other assistance. The MCO provided screenshots of the PreCheck MyScript which providers can access at the www.uhcprovider.com website for real-time prescription costs and detail.	
The MCO must monitor the application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the MCO's UM Program Policy on page 5. The MCO provided meeting minutes for QAPIC (12-13-2017) and Healthcare Quality Utilization Management (HQUM) Committee (11-21-2017 and 12-21-2017) and National Medical Care Management Committee (February 2018), which contained evidence of review of clinical practice guidelines.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Guidelines are reviewed at least annually and disseminated to all contracted practitioners and providers via the provider portal. Contracted practitioners provide input through various committees in which they participate. Monitoring of practice guidelines is done via scorecards, quality of care monitoring and HEDIS performance monitoring.	
Using information acquired through its QM and UM activities, the MCO must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and UR activities.	**Documents** Policies/procedures **Reports** Most recent written recommendations and evidence of transmittal to MLTC	Full	This requirement is addressed in the Clinical Practice Guidelines Policy on page 1 under section V.A.c.	
Service Authorization Procedures The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services	**Documents** Policies/procedures addressing all sub-elements	Full	The Level of Care Guidelines are listed and easily accessible on the MCO's website (ProviderExpress.com) under Clinical Resources/Guidelines-Policies-Manuals/Level of Care Guidelines/NE Medicaid Level of Care Guidelines, where common criteria and best practices for all levels of care as well as specific guidelines for various types of treatments are available.	
The MCO must: 1. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into MCO documents, where applicable.		Full	This requirement is addressed in the UCSMM.06.14 Initial Clinical Review Policy on page 2 and in the Utilization Management of Behavioral Health Benefits Policy on page 1. UCSMM.01.11 Document Oversight and Adherence Policy addresses the creation of approved terminology.	
2. Not require service authorization for emergency services.		Full	This requirement is addressed in the UCSMM.04.11 Consumer Safety Policy.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
3. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.		Full	This requirement is addressed in the UCSMM.06.10 Clinical Review Criteria Policy on page 2.	
4. Not arbitrarily deny a required service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors.		Full	This requirement is addressed in the UCSMM.06.10 Clinical Review Criteria Policy on page 2; however, that this applies to subcontractors is not stated in this policy. Onsite, the MCO detailed the processes they use to monitor delegates. The MCO reported that the delegates are monitored within 12 to 14 months of delegation using various standards, including the MCO's subcontracting standards as well as NCQA and State standards.	
5. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.	**Reports** Also includes evidence of monitoring including results and f/u actions taken	Full	Prior Results (2017) Substantial- Onsite, UHCCP indicated that inter-rater reliability (IRR) is conducted once a year for staff who make authorization decisions. MCO Response UnitedHealthcare Community Plan has met this requirement. The authorization team is required to take courses to obtain competence to ensure consistent application of review criteria is being completed by all staff. At the time of the audit the health plan did not have access to this report known as the Inter Reliability Report (IRR) for 2017, and the prior report was only available for 2016. This report is run between the end of October to the beginning of November of each year. The results of the 2017 MCG 21st Edition Ambulatory Care IRR, as reported by	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			LearnSource includes both raw data and pivot tables which display the results in different ways. For confidentiality, participants are only identified by their employee ID numbers. The report was run on 10/24/2017 and a copy can be provided if requested. IPRO Response The IRR report that UHCCP referenced in their response will be considered for the compliance audit for 2018. The MCO provided 2017 MCG IRR scores for 14 individuals, all of whom received a passing score of 90 or above. The MCO also submitted the UCS Annual MCG Care Guidelines Interrater Reliability Standard Operating Procedure as well as the Pharmacist Inter-Rater Reliability of Pharmacy Coverage Reviews and the Physician Inter-Rater Reliability of Pharmacy Coverage Reviews policies, which all address this requirement.	
6. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.		Full	This requirement is addressed in the PDL Change Notice Policy on page 2.	
7. Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth.		Full	This requirement is addressed in the Nebraska Medicaid Psychotropic Drugs and Youth Initiative Review Guide.	
8. Have written policies and procedures for prescribers to request peer review and peer-to-peer consultations on prior authorizations. Peer-to-peer review or peer consultation must be conducted by a State-licensed prescriber.		Full	This requirement is addressed in the UCSMM.06.15 Peer Clinical Review Policy on pages 2–3.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9. Consult with the requesting network provider, when appropriate.	**Onsite File Review** Also includes UM file review results	Full	This requirement is addressed in the UCSMM.06.15 Peer Clinical Review Policy on pages 2–3. File Review Results One (1) of 10 files reviewed required consultation with requesting network provider and evidenced this consultation in the form of communication and acquisition of additional files pertaining to the member's healthcare records. Nine (9) out of 10 files reviewed were not applicable for this requirement.	
Concurrent Review The MCO must develop a system of concurrent review for inpatient services to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.	**Documents** Policy/procedure	Full	This requirement is addressed in the UCSMM.06.16 Initial Review Timeframes Policy on page 3 and in the UCSMM.06.14 Initial Clinical Review on page 2.	
An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical guidelines. The MCO must use published and commercially available criteria for hospital case reviews to facilitate evaluation by UR nurses.	**Documents** Policy/procedure Identification of criteria used	Full	This requirement is addressed in the UCSMM.06.10 Clinical Review Criteria Policy on page 1 and in the Health Plan UM Program Policy on page 4. MCG, CMS criteria, and InterQual are cited as examples of criteria used.	
Retrospective Utilization Review of Network Providers The MCO must develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including:	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the Provider Profiling and Monitoring of Over & Under Utilization Policy, the UM Program Description on pages 7 and 29, and in the Retrospective UR Functions Policy on page 1.	

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Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
1. A system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services.			The MCO provided a sample provider utilization tracking file showing utilization rates for that provider and comparing them to the MCO averages.	
2. A reasonable appeal process that includes: standard communication with reasonable timelines, UR criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims.	**Documents** Policy/procedure	Full	This requirement is addressed in the following policies: UCSMM 07.11 Appeal Review Timelines, UCSMM 07.10 Appeal Peer Reviewer Qualifications (page 1), UCSMM 07.12 Appeal Process and Record Documentation, UCSMM 07.13 Appeal Notices, and UCSMM 07.14 Independent Review Organizations (page 2).	
3. Written policies and procedures through which the prescriber of pharmacy services is able to submit additional information for special consideration and additional review of denied prior authorization requests that do not meet criteria.	**Documents** Policy/procedure	Full	This requirement is addressed in the Pharmacy Peer-to-Peer Request Medicaid Standard Operating Procedure and in the Lack of Information Adverse Determination Job Aid.	
4. Retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary, and were authorized and billed in accordance with the MCO's requirements.	**Documents** Policy/procedure **Reports** Evidence of retrospective and peer reviews including results and f/u actions taken	Full	This requirement is evidenced by the Service Verification reports submitted by the MCO that cover the time period from July 2017 to December 2017. The letters mailed to members, the calls received from members in response to letters, the follow-up calls to verify member's responses and the follow-up actions (closed, referred for further investigation, etc.) are evidenced in these reports. The Compliance Committee Report – Retrospective (January 2018) also evidences this requirement, where case reports for each alleged compliance breach, actions taken, and status of each case are detailed.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			CS_Alert Reports also evidence this requirement, where provider awareness letters for monitored issues, like drug frequency, and outcomes (such as provider education) are documented.	
5. Provider reviews related to Medicaid compliance issues.	**Documents** Policy/procedure Example of a provider review related to compliance	Full	This requirement is evidenced by the Service Verification reports and the Compliance Committee Report – Retrospective (January 2018). Samples of actions taken based on the compliance reviews of providers evidence follow up, such as letters to providers, a retrospective investigation executive summary, as well as a quarterly tally of reviews and ongoing investigations.	
6. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.	**Documents** Policy/procedure	Full	The MCO included a narrative that explains their internal method of identifying outliers: "UnitedHealthcare Community Plan NE utilizes an internally developed report named the ToUR to review member utilization of services. This member-level report includes demographic, provider, diagnosis, care management status, IP/OP/ED/BH utilization, claims, disease state, pharmacy, and other information designed to verify member utilization of services and appropriateness of care. It is also used to ensure appropriate members are being engaged in care management, and to trigger additional outreach for members previously unable to be engaged. Data is pulled from claims sources, enrollment information, demographics, and care management documentation systems."	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			The MCO evidenced the monitoring of utilization patterns and identification of outliers with a sample ToUR report that included ER top utilizers, inpatient readmissions, medical and pharmacy high-cost members, and behavioral health top utilizers.	
7. Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under-and over- utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	Prior Results (2017) Substantial- UHCCP submitted evidence of utilization by provider and health centers, however demographic stratification was only apparent by age. Reports exist for both BH and PH services, wherein members are reviewed by geographic location and then additional demographics are available for drill-down, per onsite discussion. MCO Response In order to facilitate ease of use, the drill-down demographic information available through supplemental investigation (as discussed onsite) is being moved to the initial report. This requirement is addressed in the Provider Profiling and Monitoring of Over & Under Utilization Policy; however, monitoring of provider's utilization of services by race, ethnicity, gender, and age is not specified in this policy or in any other policy submitted by the MCO. Nevertheless, the sample UHCCP Claim Scorecard showing 2016 and 2017 quarterly data evidences monitoring of utilization with breakdown of demographics of members served by age, gender, and race/ethnicity. This scorecard monitors inpatient admissions, emergency visits,	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			pharmacy utilization, and radiology. Onsite, the MCO explained that further drill downs are performed as needed. The sample provider profile provided by the MCO lists provider utilization for discharges, hospital days, ER visits, encounters, specialty encounters, prescriptions, and prescription cost, as well as utilization by measures. It is suggested that monitoring of provider's utilization of services by race, ethnicity, gender, and age be specified in UHCCP's policy.	
The MCO must monitor for potential off-label drug usage.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the UnitedHealthcare Clinical Services, Clinical Coverage Review Oversight Policy on page 2 and in the Pharmacy Program – Nebraska on page 4. An example of an approval for a drug for off-label use also evidenced this requirement.	
The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization. For UR, the test for appropriateness of the request for emergency services must be whether a prudent layperson would have requested such services. A prudent layperson is one who possesses an average knowledge of health and medicine.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the Monitoring Emergency Service Utilization Policy. The sample ToUR report and the sample provider profile both evidence that ER visits are monitored.	
Utilization Management Committee The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-	**Documents** UM Committee description List of membership Agendas and meeting minutes for all committee meetings held during review period	Full	The HQUM Committee meeting agendas and minutes for meetings held during the review period evidence this requirement. Policies, appeals and grievances related to UM, internal UM audit results among other utilization results were documented to be reviewed and	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
chaired by the Medical Director and must report its findings to the QAPIC. The UM Committee must review, at a minimum: 1. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan. 2. Grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes. 3. Information from UM operations relevant to system gaps are identified and shared with provider network staff through this committee. 4. Results from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities.	**Reports** UM reports for review period UM Program Evaluation		discussed. Policy updates and changes based on results and the reporting of the HQUM to the QAPIC was evidenced by the agenda and minutes of the QAPIC. HQUM minutes include a list of members. The MCO indicated that the UM Program Evaluation is slated to go to the HQUM in April 2018, which is outside of the review period.	
Service Authorizations and Notices of Action **Service Authorization** The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the UM Program Description on page 14.	
The MCO 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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the UCSMM.06.15 Peer Clinical Review Policy. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Notice of Adverse Action The MCO 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.	**Documents** Policy/procedure Template notice of action	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices pages 1–2.	
The MCO 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:	**Documents** Policy/procedure	Full	This requirement is addressed in the operational policies UCSMM.06.16 Initial Review Timeframes and UCSMM.06.18 Initial Adverse Determination Notices.	
1. The action the MCO or its subcontractor has taken or intends to take.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
3. 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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices on page 1. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.18 Initial Adverse Determination Notices and the State Fair Hearing Policy. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
6. Procedures for exercising a member's rights to appeal or grieve a decision.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policies UCSMM.06.18 Initial Adverse Determination Notices and UCSMM.07.12 Appeal Process and Record Documentation. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policies UCSMM.06.16 Initial Review Timeframes and UCSMM.06.18 Initial Adverse Determination Notices. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8. 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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.07.12 Appeal Process and Record Documentation on page 2. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
The notice must be in writing and must meet the language and format requirements. [The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency. The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.]	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policies UCSMM.06.18 Initial Adverse Determination Notices, UCSMM.07.12 Appeal Process and Record Documentation, and UCSMM 03.13 Public Communication and Marketing. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	

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Timeframes for Notice of Action The MCO must provide notice to the member a minimum of ten (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 MCO must give notice by the date of the action under the following circumstances: 1. The death of a member. 2. 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. 3. The member's admission to an institution where he or she is ineligible for further services. 4. The member's address is unknown and mail directed to him/her has no forwarding address. 5. The member has been accepted for Medicaid services by another state. 6. The member's physician prescribes the change in the level of medical care.	**Documents** Policy/procedure	Full	This requirement is addressed in the operational policy UCSMM.06.16 Initial Review Timeframes.	

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7. An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989. 8. 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 nursing facility for 30 calendar days (applies only to adverse actions for nursing facility transfers).				
The MCO must provide notice on the date of action when the action is a denial of payment.	**Documents** Policy/procedure	Full	This requirement is addressed in the operational policy UCSMM.06.16 Initial Review Timeframes.	
Standard Service Authorization Denial The MCO must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed 14 calendar days following receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO 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 MCO 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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	Prior Results (2017) Substantial-9 of 10 UM files reviewed contained evidence that the notice of action was provided to the member within the appropriate timeframe (one file did not include evidence that the member received a letter, however the provider letter was sent within the appropriate timeframe). MCO Response UnitedHealthcare Community Plan has met the requirement. UHC provides notification of adverse determinations to members and providers, but only notifies providers of approvals. The ask of the NE RFP states: 3. Service Authorizations and Notices of Action b. Notice of Adverse Action i. The MCO must notify the requesting provider, and give the member written notice,	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			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 Nebraska Administrative Code states: 3-005.03 Notification of the Client: The provider or local office shall notify the client of approval or denial of prior authorization according to the prior authorization procedures under the individual chapters of this Title. The finding should be FULL for these criteria as we have met the requirements. IPRO Response Only denials were requested and reviewed as part of the compliance audit, and thus approvals were not applicable. Evidence of communication to both members and providers was anticipated within each case file. This requirement is addressed in the operational policy UCSMM.06.16 Initial Review Timeframes. File Review Results Ten (10) out of 10 files were reviewed and met this requirement.	
Expedited Service Authorization Denial For cases in which a provider indicates or the MCO 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 MCO must make an expedited authorization decision and provide notice as	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the operational policy UCSMM.06.16 Initial Review Timeframes. File Review Results Ten (10) out of 10 files were reviewed and none included an expedited service	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.			authorization; therefore, this requirement was not applicable for the file sample.	
Untimely Service Authorization Decisions The MCO 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.	**Documents** Policy/Procedure	Full	This requirement is addressed in the operational policy UCSMM.06.16 Initial Review Timeframes.	

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Grievance and Appeals **General Requirements** The MCO 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 MCO must distinguish between a grievance, grievance system, and grievance process, as defined below: 1. A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions. 2. 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. 3. A grievance process is the procedure for addressing members' grievances.	**Documents** Policy/procedure UM Program Description in place during the review period	Full	UCSMM.07.12 Appeal Process and Record Documentation addresses all three sub-elements of this requirement. UHCCP's Member Handbook (page 109) provides members with the definition of a grievance, and an overview of grievances and appeals (pages 111 to 115).	
The MCO must: 1. 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.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Member Handbook on page 113.	
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template acknowledgement notice **Onsite File Review**	Full	This requirement is partially addressed in the Member Handbook on page 126 (related to complaints only). This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure, which states	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Grievance and appeal file review results		that "Written acknowledgment of the receipt of an appeal is completed within applicable state timeframes". For ease of reference, this policy should be updated with the required state timeframe of 10 days. File Review Results Twenty (20) grievance files and 10 appeal files were reviewed. All 20 grievance files contained evidence of a timely acknowledgement letter. Of the 10 appeal files reviewed, only 9 were applicable (since there was a decision made within 3 days to overturn the initial denial for case #5). Of these 9 files, all contained evidence of a timely acknowledgement letter.	
3. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: a. The denial of service is based on lack of medical necessity. b. Because of the member's medical condition, the grievance requires expedited resolution. c. The grievance or appeal involves clinical issues.	**Documents** Policy/procedure **Onsite File Review** Grievance and appeal file review results	Full	This requirement is addressed in UCSMM.07.10 Appeal Peer Reviewer Qualifications. This policy provides an overview of the qualifications of the health care professional. This requirement is also addressed in POL2015-04 Appeal and Grievance Policy and Procedure, pages 6 and 9. File Review Results Ten (10) of 10 appeal files met this requirement (demonstrating that the individual completing the appeal review was not the same individual involved in the initial denial decision, and was an appropriate health care professional with expertise in treating the member's condition). Of the 20 grievance files reviewed, none were applicable (since they did not relate to a medical issue and were all first level reviews).	

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			Going forward, a stratified sample will be utilized, that includes quality grievances (i.e., those that are medical in nature) as well as non-medical grievances.	
4. 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.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure, pages 6 and 9. File Review Results Ten (10) of 10 appeal files met this requirement.	
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.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 8. The Member Handbook does not indicate that the member's provider can call or write on their behalf regarding a grievance. The MCO can consider including this language to improve transparency.	
A member may file a grievance with the MCO or the State at any time.	**Documents** Policy/procedure Member Handbook	Substantial	This requirement is addressed within POL2015-04 Appeal and Grievance Policy and Procedure on page 8, which states "A member may file a grievance at any time". The Member Handbook states, on page 126, that the member can send a complaint at any time. This, however, is following the section regarding civil rights, and not outlined explicitly in the grievances section of the Handbook (on page 111). Further, pertaining to civil rights, letters were updated January 2018, since they initially stated complaint had to be filed within 60 days of when grievance was experienced (as opposed to at any time). This update was approved by	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			the state in February, however the templates were not put into production until April. **Recommendation** The MCO should consider incorporating language related to filing a grievance at any time on page 111. Further, the MCO should ensure that the new template outlining the member's right to file a complaint regarding civil rights discrimination *at any time* is consistently being utilized. **MCO Response** UnitedHealthcare Community Plan has updated its Member Handbook to include language that a member may file a grievance at any time, which was approved by MLTC for use as of August 14, 2018. Further, the Health Plan has verified that the template outlining the member's right to file a complaint regarding civil rights discrimination at any time has been implemented, and will continue to monitor that it is consistently being utilized. **IPRO Final Findings** No change in review determination.	
The MCO 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 MCO receives the grievance.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Grievance file review results	Full	This requirement is addressed within the Member Handbook on page 111, which states "We will try to get you an answer in 15 working days. If that is not possible, you will get an answer in no longer than 90 calendar days from the date the complaint/grievance was filed".	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Also addressed within POL2015-04 Appeal and Grievance Policy and Procedure on page 9, which states "The standard timeframe to resolve a grievance is 90 calendar days from UHCCP's receipt or as expeditiously as the member's health condition requires". File Review Results Twenty (20) of 20 grievance files demonstrated timely notice. It was commendable to see that the notice went out within the 15 day target, as outlined in the MCO's Member Handbook.	
MLTC will establish the method the MCO must use to notify a member of the disposition of a grievance.	**Documents** Policy/procedure Template grievance resolution notice **Onsite File Review** Grievance file review results	Full	This requirement is addressed within POL2015-04 Appeal and Grievance Policy and Procedure on page 9, which states that the notification letter must include the following elements: 1. The letter is addressed to the grieving party, and where applicable, the provider or facility. 2. The specific reason(s) for the decision, in easily understandable language. 3. The right of a member to appeal a grievance decision. File Review Results Twenty (20) of 20 grievance files demonstrated an appropriate method by which the MCO notified members of the disposition of a grievance.	
Appeal Processes A member may file a MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed within POL2015-04 Appeal and Grievance Policy and Procedure on page 4, and within the Member Handbook on page 112.	

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Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed within the Member Handbook on page 112, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 5.	
The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed within the Member Handbook on page 112, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 4.	
The MCO must: 1. 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.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 4. File Review Results Ten (10) appeal files were reviewed. Nine (9) of these files were not applicable, as they did not contain a verbal inquiry to appeal, but rather an inquiry in writing. The 1 applicable file contained evidence that the verbal inquiry was confirmed in writing.	
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in Policy UCSMM.07.12 Appeal Process and Record Documentation.	
3. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	This requirement is addressed in the Member Handbook on page 112 and in POL2015-04 Appeal and Grievance Policy and Procedure on page 6. File Review Results Ten (10) out of 10 appeal files contained evidence of this requirement.	

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4. 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 MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	This requirement is addressed in the Member Handbook on page 113 and in POL2015-04 Appeal and Grievance Policy and Procedure on pages 6 and 7. File Review Results Ten (10) out of 10 appeal files contained evidence of this requirement.	
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 2, with the description of an authorized representative, and on page 6, with the acknowledgement of the deceased member's legal representative.	
The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO 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 MCO must: 1. Make reasonable efforts to give the member prompt verbal notice of the delay. 2. Within two (2) 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.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Substantial- The timeliness standard was met in 10 of 10 appeal files. Nine (9) of 10 files did not require an extension. In the 1 file that required an extension, there was no evidence of a phone call to the member to give verbal notice of the delay. MCO Response UnitedHealthcare Community Plan has in place an SOP which requires resolving analysts to contact members verbally to inform them of extensions. UnitedHealthcare Community Plan reviewed the recommendation and determined that the resolving analyst that worked this particular case failed to contact the member verbally to inform them of the extension as outlined in the standard operating procedure. The standard operating procedure was reviewed to ensure appropriate direction is	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.			provided to the analysts and we verified the process is clearly documented directing the analysts to make a verbal attempt to the member and document the call in ETS. The resolving analyst that worked this case has been coached along with the rest of the team as a reminder that a verbal attempt and documentation is required on member extensions. The Member Handbook (page 112) addresses the acceptable timeframes for the MCO to resolve the appeal. This requirement is also addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 7. File Review Results Ten (10) out of 10 appeal files demonstrated evidence that the appeal was resolved within 30 days. There were no files that represented an extension.	
The MCO must provide written notice of disposition, which must include: 1. The results and date of the appeal resolution; and 2. For decisions not wholly in the member's favor: a. The right to request a state fair hearing. b. How to request a state fair hearing. c. The right to continue to receive benefits pending a hearing. d. How to request the continuation of benefits. e. If the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.	**Documents** Policy/procedure Template appeal resolution notice **Onsite File Review** Appeal file review results	Full	Addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 7. File Review Results Ten (10) out of 10 appeals files contained the written resolution notice to the member, which included results and date of appeal resolution. Three (3) out of 10 appeals files contained the required information regarding decisions not wholly in the member's favor (7 files were not applicable, as these appeals were overturned, and thus appropriately did not contain information related to a state fair hearing).	

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Expedited Appeals Process The MCO must establish and maintain an expedited review process for appeals that the MCO 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.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 7.	
The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 4, and in the Member Handbook on page 113.	
The MCO 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.	**Documents** Policy/procedure Member Handbook Template notice of action **Onsite File Review** Appeal file review results	Full	This requirement is addressed in the Member Handbook on page 113 and in POL2015-04 Appeal and Grievance Policy and Procedure on page 6. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals.	
The MCO 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 MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in the Member Handbook on pages 112 and 113, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 7. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals.	

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For any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in the Member Handbook on page 112, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 7. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no extensions made.	
In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 6. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals.	
The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 8.	
If the MCO denies a request for expedited resolution of an appeal, it must: 1. Transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days. 2. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 6.	

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Continuation of Benefits The MCO must continue a member's benefits if any one of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Ten (10) calendar days after the MCO mailing the Notice of Action; or b. The intended effective date of the MCO's proposed action. 2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. 3. The services were ordered by an authorized provider. 4. The authorization period has not expired. 5. The member requests an extension of benefits.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 5.	
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: 6. The member withdraws the appeal or request for state fair hearing. 7. The member does not request an appeal within ten (10) calendar days from when the MCO mails an adverse resolution to the member's appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 5.	

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8. A state fair hearing decision adverse to the member is made. 9. 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.	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on page 113, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 7.	
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 his/her representative may request a state fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.	**Documents** Policy/procedure Member Handbook Provider Manual Template appeal resolution notice-upheld decision	Full	This requirement is addressed in the Member Handbook on page 113, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 7.	
If the MCO 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 MCO.	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on page 113, and in POL2015-04 Appeal and Grievance Policy and Procedure on page 7.	
The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.	**Documents** Policy/procedure Template appeal resolution notice-upheld decision	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 7.	
The parties to the State fair hearing include the MCO, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on page 113.	

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Reversed Appeals If the MCO 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 MCO 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 MCO receives notice reversing the determination.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 Appeal and Grievance Policy and Procedure on page 8.	
The MCO must pay for disputed services if the MCO 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.	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on page 113, and in POL2015-04 on page 5.	
Grievance and Appeal Recordkeeping Requirements The MCO 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. A general description of the reason for the appeal or grievance. b. The date the grievance or appeal was received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance process, as applicable. e. Date of resolution at each level of the appeal or grievance process, as applicable. f. Name of the covered person by or for whom the appeal or grievance was filed.	**Documents** Policy/procedure	Full	This requirement is addressed in POL2015-04 on page 8.	

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The MCO 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 MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract: a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing. b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.	**Documents** Provider Manual Template provider contract Template subcontractor agreement	Full	This requirement is addressed in the Provider Manual on pages 93 and 94.	

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May 2018
Period of Review: September 1, 2017 – March 31, 2018
MCO: UnitedHealthcare Community Plan

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings. d. The toll-free number(s) to use to file verbal grievances and appeals. e. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO 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. f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.				
Reporting of Complaints, Grievances, and Appeals The MCO is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals. Member Grievance System reports due date: 15th day of following calendar month for 1st 6 months than 45 calendar days following most recent quarter.	**Documents** Policy/procedure **Reports** Member Grievance System reports for grievances, appeals, expedited appeals and state fair hearings submitted during the review period	Full	UHCCP submitted Grievance System logs for Q3 and Q4 of 2017 to provide evidence that this requirement is being met.	