NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

Care Management					
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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			
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 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.	**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			

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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 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			
The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services.	**Documents** Policy/procedure Program Description Evidence of identification of members requiring medium/ intensive CM based on their chronic conditions	Full			
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	Full			

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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.	community resources View community resource tool/ directory onsite				
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			
The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major components of CM include advocacy,	**Documents** Policy/procedure Program Description	Full			

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communication, problem-solving, collaboration, and empowerment.					
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			
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			
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	Full	The requirement is addressed in the policy and procedure for Maintaining Policy Documents. On site, the MCO discussed that staff training and in-services are conducted on a regular basis. Mandatory new hire training is given to every new CM employee. Various trainings about policies and procedures are conducted monthly through "lunch and learns," webinars, and weekly trainings. The Optum division of the MCO is given continuing education and trainings through webinars and grand rounds.	
Health-Risk Screening/Assessment The MCO must provide a health-risk screening to all members on enrollment to identify members in need	**Documents** Policy/procedure	Full			

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of CM services.	Template screening instrument **Reports** Examples of CM reports showing completion rates by new enrollees				
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			
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).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full			

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7. Instrumental activities of daily living (including medication management, money management, meal 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			
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	Full			

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	medium or high risk level based upon high costs or potentially high costs				
The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.	**Documents** Policy/procedure	Full			
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			
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			
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			

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2. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.	**Documents** Policy/procedure Program Description **Onsite File Review** CM file review results	Full			
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			
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			
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 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.	**Documents** Policy/procedure Program Description **Onsite File Review** CM file review results	Full			
6. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a	**Documents** Policy/procedure	Full			

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member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.	Program Description **Onsite File Review** CM file review results				
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			
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	Full	Full	The requirement is addressed in the following policies and procedures: Advanced Care Planning Care Management & Care Coordination	
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	Full	The requirement is addressed in the following policies and procedures: Care Management & Care Coordination Unable to Reach (UTR) On site, the MCO elaborated on the process called “feet on the street.” This form of additional outreach to members referred to CM or identified as needing care management is implemented after telephonic outreach was unsuccessful. The process is conducted by the non-clinical staff in collaboration with the care managers and care navigators to locate and engage difficult-to-find members. The CM staff	

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				meets the members in their home or residence and more face-to-face visits are conducted. This process has helped develop trust and better relationships between the MCO and the member. This form of outreach had also been implemented by the MCO in the Healthy First Step Program toward mothers who are hard to find and after seven days of unsuccessful telephonic outreach.	
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	Full	The requirement is addressed in the Care Management & Care Coordination Policy.	.
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	Full	The requirement is addressed in the following policies and procedures: 2019 Care Provider Manual Policy and procedure for Case Management Process Coordination with MLTC Programs and Other Community-Based Services Management of Care Transitions	
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	**Documents** Policy/procedure	Full	Full	The requirement is addressed in the Care Management & Care Coordination Policy.	

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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.					
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 ongoing special conditions that require a course of treatment or regular care monitoring.	**Documents** Policy/procedure	Full	Full	The requirement is addressed in the Care Management & Care Coordination Policy and in the January 2019 Healthy First Step Program Description.	
7. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	**Documents** Policy/procedure	Full	Full	The requirement is addressed in the Management for Care Transition 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	Full	The requirement is addressed in the Management of Care Transition Policy.	
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	Full	The requirement is addressed in the Management of Care Transition Policy.	
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	Full	The requirement is addressed in UCSMM.06.21 Out-of-Network Request and Continuing Care. On site, the MCO indicated that, in addition to the access to non-contracted providers for 90 calendar days, they ensure continuity of	

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				care by giving the member a defined period of time to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider. The MCO makes accommodations for specific medical circumstances; for instance, if a member is in the seventh month of pregnancy, the member continues to receive services from the terminated provider until the member gives birth. For members who are receiving hemodialysis treatments where the member can only transition to an in-network dialysis unit based upon the availability of treatment, the member is allowed to receive treatment from the terminated hemodialysis provider until such time that the transition is made possible.	
11. A process that ensures continuity of care for members with SHCNs who are in CM.	**Documents** Policy/procedure	Full	Full	The requirement is addressed in the Care Management & Care Coordination Policy.	
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			
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			
3. Educate provider office staff about symptoms of	**Documents**	Full			

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exacerbation(s) and how to communicate with patients.	Policy/procedure Examples of education provided to office staff				
4. Develop speaking points and triggers for making emergency appointments.	**Documents** Policy/procedure Onsite discussion	Full			
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			
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			
2. Provide list of community resources (for referral).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full			
3 Plan for coordination and communication with State staff who are responsible for management of	**Documents** Policy/procedure	Full			

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HCBS waivers.					
4. Develop a process to engage non-compliant members.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full			
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			
6. Identify providers with special accommodations (e.g., sedation dentistry).	**Documents** Policy/procedure Provider directory	Full			
7. Educate staff about barriers members may experience in making and keeping appointments.	**Documents** Evidence of staff education	Full			
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			
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			
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:	**Documents** Policies/procedures	Full			

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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.					
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			
The MCO must attempt to ascertain whether a	**Documents**	Full			

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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.	Policy/procedure **Onsite File Review** CM file review results				
The MCO is responsible for ensuring coordination between its providers and the WIC program. Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.	**Documents** Policy/procedure	Full			
The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.	**Documents** Policy/procedure Onsite discussion	Full			
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			

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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			

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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			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

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**	**Prior Determination**	**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**
GRIEVANCES 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			
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			
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	Full			

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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**	**Prior Determination**	**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**
	Onsite File Review Grievance and appeal file review results				
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** Grievances and appeal sfile review results	Full			
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** Appeals file review results	Full			
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			

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A member may file a grievance with the MCO or the State at any time.	**Documents** Policy/procedure Member handbook	Partial 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 the initially stated complaint had to be filed within 60 days of when grievance was experienced (as opposed to at any time). This update was approved by the state in February; however, the templates were not put into production until April. **Recommendation** The MCO should consider incorporating language on page 111 of the member handbook related to filing a grievance at any time. 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.	Full	This requirement is addressed in the member handbook, page 109 and in the National Medicaid Member Appeal and Grievance Policy, page 10.	
The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes	**Documents** Policy/procedure	Full			

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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**	**Prior Determination**	**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**
and not to exceed 90 calendar days from the day on which the MCO receives the grievance.	Member handbook **Onsite File Review** Grievance file review results				
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			
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			
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			
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			

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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**	**Prior Determination**	**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 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			
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member handbook Provider manual	Full			
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			
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			
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full			
The MCO must resolve each appeal, and provide notice,	**Documents**	Full			

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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**	**Prior Determination**	**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**
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. 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.	Policy/procedure **Onsite File Review** Appeal file review results				
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			

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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**	**Prior Determination**	**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**
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			
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			
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	Full	This requirement is addressed in the member handbook, page 111. File Review Results Of the five expedited appeals files reviewed, all five files met the requirement.	
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	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Full	This requirement is addressed in the Appeal Review Timeframes Policy and in the Grievances and Appeals Policy, pages 6 and 7. File Review Results Of the five expedited appeals files reviewed,	

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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**	**Prior Determination**	**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**
reason(s) why the delay is in the member's interest.				all five files met the requirement.	
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	Full	This requirement is addressed in the Grievances and Appeals Policy, page 7. File Review Results Of the five expedited appeals files reviewed, all five files were not applicable for this requirement, as there were no requests for extension.	
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	Full	This requirement is addressed in the Grievances and Appeals Policy, pages 6 and 7. File Review Results Of the five expedited appeals files reviewed, all five files met the requirement.	
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			
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			

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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**	**Prior Determination**	**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**
Continuation of Benefits The MCO must continue a member's benefits if all of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Within ten (10) calendar days of the MCO sending the Notice of adverse benefit determination; or b. The intended effective date of the MCO's proposed adverse benefit determination. 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 period covered by the authorization has not expired.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Grievances and Appeals Policy, 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 fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. 8. The state fair hearing office issues a hearing decision adverse to the member. 9. The authorization expires or authorization service	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Grievances and Appeals Policy, page 5.	

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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**	**Prior Determination**	**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**
limits are met.					
The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action to the extent that the services were furnished solely because of the requirements of this section.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Appeal Process and Record Documentation Policy and the member handbook, page 111.	
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			
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			
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			
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	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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's estate.					
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			
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			

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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**	**Prior Determination**	**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 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. The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.	**Documents** Policy/procedure	Full			
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. c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings.	**Documents** Provider manual Template provider contract Template subcontractor agreement	Full			

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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**	**Prior Determination**	**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**
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			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

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**	**Prior Determination**	**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			
Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those rights will not adversely affect the member's	**Documents** Policy/procedure	Full			

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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**	**Prior Determination**	**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**
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			
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 received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.	**Documents** Policy/procedure Template notice of provider termination	Partial This requirement is addressed in the Policy and Procedure for UHC Community- and State Provider-Initiated Voluntary Termination that states the notice to the member must be provided within 15 calendar days from the receipt of the termination notice from the provider. Actual letters were provided regarding voluntary termination of providers (as opposed to template letters). Two of these letters were sent 60 days after receipt of the termination notice from the provider and one was sent at almost 90 days. **Recommendation** UHCCP should examine the timeliness of the letters that are distributed	Full	This requirement is addressed in the Potential and Actual Provider Terminations Policy on pages 2 and 3. Actual letters were provided regarding termination of providers (as opposed to template letters). Some of these letters were dated within 3 days of provider termination. Some were dated within 30 days. Most of these letters were dated more than 30 calendar days after the termination date included in the letters. Some of the letters were dated almost six months after	

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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**	**Prior Determination**	**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**
		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.		the termination date. These letters were all dated before 9/13/2018, when the Potential and Actual Provider Terminations Policy was last revised. On site, the MCO explained that they do not always find out about provider terminations in a timely manner; however, once they do find out about termination, they provide members with notices of termination within 15 calendar days. To evidence this, the MCO provided several emails that demonstrated termination letters dated on the same date in which the provider termination report was run (8/6/2018). For one provider, the MCO found out about termination on 8/4/2018 and the letters to members were sent on 8/6/2018. As a result, the MCO evidenced timely notices to members of provider notices for all the sample letters they provided.	
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			

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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**	**Prior Determination**	**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**
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			
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 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	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.					
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			
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			
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 find on the website and how to obtain written materials if the member does not have access to the website.	**Documents** Policy/procedure Member materials for new members	Full			
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			

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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**	**Prior Determination**	**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**
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			
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			
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			
The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.	**Documents** Policy/procedure Sample marketing materials	Full			
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			

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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**	**Prior Determination**	**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**
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			
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 may receive a new hard copy if they want it, and the process for requesting it.	**Documents** Policy/procedure Member handbook View website onsite Onsite discussion	Full	Full	This requirement is addressed in the Member Handbook Updates and Distribution Policy. The member handbook in English and Spanish is accessible on the MCO's website for members and non-members alike.	
At a minimum, the member handbook must include: 1. A table of contents.	**Documents** Member handbook should address all sub-elements	Full			
2. A general description of basic features of how		Full			

Final Findings

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**	**Prior Determination**	**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**
MCOs operate and information about the MCO in particular.					
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			
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			
5. Member rights/protections and responsibilities.		Full			
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 another person, could result in loss of the member's Medicaid eligibility and/or legal action.		Full			
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			
8. A description of the PCP selection process and		Full			

Final Findings

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**	**Prior Determination**	**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 PCP's role as coordinator of services.					
9. The member's right to select a different MCO or change providers within the MCO.		Full			
10. Any restrictions on the member's freedom of choice of MCO providers.		Full			
11. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.		Full			
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			
13. Procedures for obtaining benefits, including authorization requirements.		Full			
14. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.		Full			
15. Information about health education and promotion programs, including chronic care management.		Full			
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full			
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			
18. Information about a member's right to a free second opinion and how to obtain it.		Full			

Final Findings

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**	**Prior Determination**	**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**
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			
20. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.		Full			
21. How to obtain emergency and non-emergency medical transportation.		Full			
22. Information about the EPSDT program and the importance of children obtaining these services.		Full			
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			
24. Information about member copayments.		Full			

Final Findings

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**	**Prior Determination**	**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**
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			
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			
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			
28. Member grievance, appeal, and state fair hearing procedures and timeframes, as follows: a. For grievances and appeals: 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.		Full			

Final Findings

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**	**Prior Determination**	**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**
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. 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.		Full			
29. A description of advance directives that includes: a. The State's and MCO's policies about advance		Full			

Final Findings

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**	**Prior Determination**	**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**
directives. b. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.					
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			
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			
32. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the MCO. 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.		Full			
33. A minimum of once a year, the MCO must		Full	Full	This requirement is addressed in the	

Final Findings

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**	**Prior Determination**	**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**
notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.				Member Handbook Updates and Distribution Policy on page 1.	
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	Full	This requirement is addressed in the Annual Notice to Members Policy on page 2. This requirement is evidenced in the template annual notice letter on page 2. On site, the MCO provided evidence of actual member notifications sent on 8/17/2018, which is more than 60 calendar days before the start of the 2018 enrollment period (November 1).	
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. 2. An updated provider directory, at no cost to the member.	**Documents** Policy/procedure Evidence of member notification	Full	Full	This requirement is addressed in the Annual Notice to Members Policy on page 2. Included in the template annual notice letter is language indicating that members can access the member handbook or provider directory online and call to request a provider directory; however, the language in the member handbook and the annual notice letter template does not indicate that this is at a minimum of annually or at no cost to the member. On site, the MCO confirmed that the handbook and the provider directory are provided to the members at no cost, as per the Annual Notice to Members Policy. On site, the MCO provided evidence of actual member notifications with this information sent on 8/17/2018.	

Final Findings

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**	**Prior Determination**	**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 should consider following a best practice by adding language that member handbook and provider directory will be provided to members annually upon request 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	Full	This requirement is addressed in the UnitedHealthcare Community Plan Member Education Plan on page 12. This plan indicates that the MCO has quarterly member newsletters. The requirement is evidenced by the spring 2018 and winter 2018 member newsletters provided by the MCO.	
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	**Documents** Policy/procedure Provider directory View website onsite	Full			

Final Findings

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**	**Prior Determination**	**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, potential members, and the general public. 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			
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			
Member Website The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices,	**Documents** Policy/procedure View website onsite	Full			

Final Findings

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**	**Prior Determination**	**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**
and have the capability for bi-directional communications (i.e., members can submit 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	**Documents** Policy/procedure View website onsite	Full			

Final Findings

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**	**Prior Determination**	**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**
prominently displayed and a telecommunications device for the deaf (TDD) number. 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.	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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 is prohibited from conditioning the provision of care or otherwise discriminating 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.					

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

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**	**Prior Determination**	**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**
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			
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			
There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.	**Documents** Policy/procedure	Full			
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			
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 1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	Full	This requirement is addressed in the Network Development Plan. UHCCP submitted all subcontractor and provider agreements as evidence of compliance with this requirement.	

Final Findings

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**	**Prior Determination**	**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**
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. 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					

Final Findings

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**	**Prior Determination**	**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 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. 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.					

Final Findings

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**	**Prior Determination**	**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 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. 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.					

Final Findings

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**	**Prior Determination**	**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 must take corrective action if it, or its providers, fail to comply with the timely access requirements.	**Documents** Policy/procedure	Full			
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			
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 advertise or otherwise hold itself out as having an exclusive relationship with any provider.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full			
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			
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			
The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
mental disabilities.	Provider directory Onsite discussion				
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			
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			
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. 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.	**Documents** Policy/procedure	Full			
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,	**Documents** Policy/procedure Template provider	Full			

Final Findings

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**	**Prior Determination**	**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**
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): 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.	contract – one per provider type Provider manual				
If the MCO knowingly executes a subcontract with a provider	**Documents**	Full			

Final Findings

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**	**Prior Determination**	**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**
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.	Policy/procedure				
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 corrective measures shall subject the MCO to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full			
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.	**Documents** Policy/procedure	Full			
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			

Final Findings

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**	**Prior Determination**	**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 must provide an adequate network of (PCPs) to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. 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.	**Documents** Policy/procedure	Full			
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 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			
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			
The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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.	Onsite discussion				
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 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			
Contracting with FQHCs and RHCs A MCO must offer to contract with all FQHCs and RHCs in the	**Reports** Geographical access	Full	Full	This requirement is addressed in the Network Development Plan and in the Q4	

Final Findings

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**	**Prior Determination**	**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**
State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.	reports Onsite discussion			Geographical Access Reports.	
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. 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.	**Documents** Policy/procedure Network Development Plan Onsite discussion	Full	Full	This requirement is addressed in the Adequate Capacity and Services Policy.	
Appointment Availability and Referral Access Standards Nebraska's appointment availability standards are					

Final Findings

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**	**Prior Determination**	**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**
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			
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			
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			

Final Findings

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**	**Prior Determination**	**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 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 follow-up actions	Full			
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 follow-up actions	Full			
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 follow-up actions	Full			
Geographic Access Standards	**Documents**	Full	Full	This requirement is addressed in the	

Final Findings

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**	**Prior Determination**	**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 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.	Policy/procedure Requests for exception submitted to MLTC **Reports** Evidence of geographical access monitoring, including results and follow-up actions			Adequate Capacity and Services Policy and in the Network Development Plan. The MCO also submitted Q4 2018 Geographical Access Report as evidence of compliance with this requirement.	
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	Full	This requirement is addressed in the Network Development Plan.	
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 follow-up actions	Full	Full	This requirement is addressed in the Network Development Plan, the Q4 2018 Geo Access Report, and in the Adequate Capacity and Services Policy.	
Provider Credentialing and Re-Credentialing The MCO is required to establish and implement written policies for the selection and retention of providers, consistent	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.					
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 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.	**Documents** Policy/procedure Template denial letter	Full			
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			
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	**Documents** Policy/procedure **Onsite file review** Credentialing file review	Full	Full	This requirement is addressed in the Credentialing Plan. **Credentialing File Review Results** Ten (10) of 10 files met all requirements.	

Final Findings

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**	**Prior Determination**	**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**
authority and action.	results				
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 quality reviews, results of member satisfaction surveys, and utilization management information.	**Documents** Policy/procedure **Onsite file review** Recredentialing file review results	Full	Full	This requirement is addressed in the Credentialing Plan. **Recredentialing File Review Results** Four of four 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			
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	**Documents** Policy/procedure View network provider database onsite	Full			

Final Findings

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**	**Prior Determination**	**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. Cultural and linguistic capabilities 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			
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	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, eligibility/enrollment data, utilization data, network inventory, demographic	**Documents** Policy/procedure Network Development Plan	Full	Full	This requirement is addressed in the Network Development Plan.	

Final Findings

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**	**Prior Determination**	**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**
(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	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	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	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	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	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	Full	This requirement is addressed in the Network Development Plan.	

Final Findings

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**	**Prior Determination**	**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**
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			
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			
Evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full			
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.	**Documents** Policy/procedure	Full			
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			
Process provisional credentials for behavioral health service providers.	**Documents** Policy/procedure	Full			
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			
Provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full			
Educate its provider network regarding appointment time requirements.	**Documents** Policy/procedure	Full			

Final Findings

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**	**Prior Determination**	**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**
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 follow-up actions	Full			
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. 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	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full			

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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**	**Prior Determination**	**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**
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			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
PROVIDER SERVICES **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	Full	This requirement is addressed in the Community and State Provider Appeals and Complaints Standard Operating Procedure.	
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	Full	This requirement is addressed in the Provider Appeals and Complaints Standard Operating Procedure (SOP).	
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:	**Documents** Policy/procedure Provider manual Template complaint resolution notice Complaint system standardized reports **Onsite File Review** Provider complaint file review **Onsite discussion:** Review complaint system	Full	Partial	This requirement is addressed in the Provider Appeals and Complaints SOP and in the Provider Complaint and Claims Dispute System. **Provider Complaint File Review Results** Seven (7) of 10 files met all requirements. In 3 files, there was no evidence that the provider received a resolution notice or an explanation of payment. UHCCP submitted a spreadsheet in lieu of tangible files prior to the onsite review. The spreadsheet contained the nature and/or substance of each complaint. On site, the MCO provided supporting documentation for the complaint files that included	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	metrics including year over year comparisons of complaint volumes			Resolution Notices and Explanations of Payment (EOP). It was discussed that the provider services staff at UHCCP sends out resolution notices to only those providers to which a complaint remains a complaint within the purview of the provider services staff. Should a complaint be escalated to a grievance that involves a claim, an EOP is sent to the provider. The EOP, in these instances, is considered the resolution notice. **Recommendation** For the next annual review, UHCCP should submit the entire case file for each complaint requested. Each provided complaint file should contain a Resolution Notice or EOP to the provider. **MCO Response** We have reevaluated our process and are redesigning the workflow to ensure all documentation and communication related to the provider grievance will be entered into our escalation tracking system (ETS). The ETS systems reporting capabilities will help to ensure that all complaints receive the appropriate provider correspondence and resolution letters. **IPRO Final Findings** No change in review determination.	
1. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the		Full	Full	This requirement is addressed in the provider manual.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.		Full	Full	This requirement is addressed in the provider manual.	
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.		Full	Full	This requirement is addressed in the provider manual.	
4. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues.		Full	Full	This requirement is addressed in the provider manual.	
5. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.		Full	Full	This requirement is addressed in the provider manual.	
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.		Full	Full	This requirement is addressed in the provider manual.	
7. A process for giving providers (or their representatives) the opportunity to present their cases in person.		Full	Full	This requirement is addressed in the provider manual.	
8. Identification of specific individuals who have authority to administer the provider complaint process.		Full	Full	This requirement is addressed in the provider manual.	
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.		Full	Full	This requirement is addressed in the provider manual.	
The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the provider manual.	

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	Provider manual View website onsite				
The MCO must develop an internal claims dispute process for those claims that have been denied or underpaid. The process for appealing payment and service denial decisions must be included in the provider handbook.	**Documents** Policy/procedure Provider manual **Onsite File Review** Provider appeal of claim/service denial file review	New requirement	Full	This requirement is addressed in the Provider Complaint and Claims Dispute System and in the provider manual. **Provider Appeal File Review Results** Ten (10) of 10 files met all requirements.	

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 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. 5. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program.	**Documents** QM Program Description	Full			
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	**Documents** QM Program Description	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
tracking and trending of issues, throughout all areas of the organization.	Corporate organizational chart QM department organizational chart				
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			
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: 45 calendar days following 12th month of contract year	**Documents** QM Program Description	Full	Full	This requirement is addressed within UnitedHealthcare Community Plan's (UHCCP's) 2018 QI Program Description. QM objectives are also outlined in the MCO's work plan.	
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. 2. Evaluation and reporting of findings. 3. Implementation of improvement actions, where applicable. 4. Individual accountability for each activity. QM work plan due date: 45 calendar days following 12th month of contract year	**Documents** QM Work Plan	Full	Full	This requirement is addressed within UHCCP's QI Work Plan.	
Procedures for remedial action for deficiencies that are identified.	**Documents** QM Program Description	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	Policy/procedure				
Specific types of problems requiring corrective action.	**Documents** QM Program Description Policy/procedure	Full			
Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.	**Documents** QM Program Description Policy/procedure	Full			
Procedures for provider review and feedback about results.	**Documents** QM Program Description Policy/procedure	Full			
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 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	**Documents** QM Evaluation Onsite discussion	Full	Full	This requirement is evidenced within the MCO's 2018 Quality Improvement Program Evaluation. The non-clinical Quality Performance Program (QPP) measures were provided in a PowerPoint file and demonstrate the MCO is meeting or exceeding all contractual requirements.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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'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: 45 calendar days following 12th month of contract year Quality Performance Program Measures for Year 2 per Attachment 14 as per Amendment Three include: 1. Claims Processing Timeliness 2. Encounter Data Acceptance Rate 3. Call Abandonment Rate 4. Appeal Time Resolution 5. PDL Compliance 6. Lead Screening in Children 7. Well Child Visits in the First 15 Months of Life 8. Childhood Immunization Status					
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			
QAPI Program The MCO's QAPI program, at a minimum, must comply with State	**Documents** QM Program Description	Full			

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.					
At a minimum, assess the quality and appropriateness of care furnished to members.	**Documents** QM Program Description	Full			
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			
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			
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	Full	This requirement is addressed in the Member Handbook on page 85, the spring 2019 member newsletter, and the Provider Manual on page 77.	
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, MLTC, members, family members, providers, and other stakeholders.	**Documents** Description of methods used to solicit feedback and recommendations Onsite discussion	Full	Full	This requirement is addressed within the QI Program Description, which details committees that are attended by providers, members, and other key stakeholders that are encouraged to provide feedback and insight. Further, this requirement is evidenced within the Quality Management Committee (QMC) meeting minutes.	
Require that the MCO make available records and other	**Documents**	Full	Full	This requirement is addressed in the QI	

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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.	QM Program Description			Program Description on page 4.	
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			
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. 5. The MCO's Provider Services Manager. 6. Family members/guardians of children or youth who are Medicaid members. 7. Adult Medicaid members.	**Documents** QAPIC membership	Full			

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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.					
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. 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	**Documents** QM Program Description Agendas and meeting minutes for all committee meetings held during review period	Full	Full	This requirement is addressed in the documentation for QMC training conducted May 2018. It is also addressed in the QI Program Description on pages 9–11, and evidenced within the QMC meeting minutes.	

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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	Full	This requirement is addressed within the QI Program Description. All additional committees are cited, along with the stipulation of quarterly reporting to QMC.	
Data Collection The MCO must collect performance data and conduct data analysis with the goal of improving members' 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.	**Reports** Reports of state-required performance measures	Full	Full	This requirement is evidenced within the performance measures submitted by the MCO, as well as within the PIPs.	
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	**Documents** Process for verifying the accuracy and completeness of provider- and vendor-reported data Process for screening data for completeness, logic and consistency	Full	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. A process for verifying the accuracy and completeness of information is evidenced within the policy HEDIS Data Auditing (Internal & External).	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 to MLTC 45 calendar days following the most recent quarter	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				
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	Full	This requirement is addressed within the QI Program Description, HEDIS Data Auditing (Internal & External) and QM 101 Performance Measures Monitoring and Analysis. Data collected for performance measures and PIPs were submitted to MLTC on time and in an acceptable format.	
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®)	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS Final Audit Report	Full	Full	This requirement is addressed. UHCCP demonstrated timely submission of the following state-required performance measure reports/files: HEDIS 2018 Adult Core Measures HEDIS 2018 Child Core Measures 2018 CAHPS Adult Medicaid Report 2018 CAHPS Child Medicaid w/CCC Report	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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: June 30 **Attachment 7:** <u>Adult Core Measures</u> 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	and IDSS rates CAHPS Report Onsite discussion				

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(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) 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)					

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 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	**<u>Reports</u>** HEDIS Final Audit Report	Not applicable: HEDIS performance measures were not evaluated within the timeframe associated with this year's compliance review; however,	Full	This requirement is addressed in HEDIS Data Auditing (Internal & External), and within	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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.	and IDSS rates	data collection processes are well documented within QM 101 HEDIS Rate Monitoring and Analysis, and HEDIS Data Auditing (Internal & External).		the final audit report produced by Attest Health Care Advisors.	
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; however, data collection processes are well documented within QM 101 HEDIS Rate Monitoring and Analysis and HEDIS Data Auditing (Internal & External). Further, UHCCP's QI Program provides evidence that the MCO trends performance and identifies barriers to achieving their goals.	Full	This requirement is addressed in QM 101 Performance Measures Monitoring and Analysis. Trending of performance measures is evidenced within the MCO's quality metrics scorecard.	
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 Audit Report and IDSS rates Review of website Onsite discussion	Full	Full	UHCCP provided interim PIP reports for each of the three topic areas. These topics were selected based on state priorities and 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 other two PIPs (Tdap and 17p) rely on measures crafted by IPRO and MLTC. The PIPs are reported to and validated by IPRO annually, with updates provided quarterly.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 follow-up actions taken	Full	Full	This requirement pertaining to sampling is addressed in HEDIS Data Auditing (Internal & External). Evidence of performance measure trending is demonstrated within the QMC meeting minutes, wherein the committee reviews year-over-year rates as well as corrective actions and incentives that are in place to improve these rates.	
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	Full	UHCCP provided interim PIP reports that reflect activity from CY 2018 for each of the three topic areas. These topics were selected based on state priorities and 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 other two PIPs (Tdap and 17p) rely on measures crafted by IPRO 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	Full	The Heritage Health MCOs collaborate 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.	**Documents** QM Program Description QM Work Plan QM Evaluation	Full	Full	PIPs are addressed in the QI Program Description, the QI Work Plan, and QI Program Evaluation. Each of the PIP interim reports that were submitted for review contained each of the	

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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. 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.				necessary CMS requirements.	
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	Full	Full	The status of each PIP is appropriately included in the QI Program Evaluation. Findings and next steps are discussed during the quarterly QMC and CPAC meetings.	

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	QM Evaluation			Updates from these meetings are reviewed and noted within the work plan.	
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	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 apply 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.	Full	Amendment 3 to the Heritage Health contract included additional performance measures, which are recorded and analyzed within the MCO's QI Program Evaluation.	
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	Full	UHCCP contracted with DSS Research, 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	Full	UHCCP submitted CAHPS Adult And Child Survey Reports. For the child survey component, the MCO appropriately separated the sample of Medicaid and CHIP populations and reported results accordingly.	
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	Full	This requirement was addressed within the reports DSS Research prepared on behalf of UHCCP.	
Each survey must be administered to a statistically valid random	**Reports**	Full			

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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.	CAHPS Adult And Child Survey Reports Onsite discussion				
Survey results and descriptions of the survey process must be reported to MLTC separately for each 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: 45 calendar days following 12th month of contract year	**Reports** CAHPS Adult And Child Survey Reports Onsite discussion	Full	Full	This requirement was addressed within the reports DSS Research prepared on behalf of UHCCP.	
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	Full	This requirement is addressed, per evidence provided within the provider survey tool, letter, and survey results.	
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	**Documents** Provider satisfaction survey tool and methodology Onsite discussion	Full	Full	This requirement is addressed in Provider Survey Results Annual Report (calendar year 2018). The final sample size included 1,800 providers that consisted of physicians, behavioral health, and ancillary and facility providers. There were 52 responses received for UnitedHealthcare Community Plan of	

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and clinical experience.				Nebraska. This represents a 2.8% response rate, which is substantially lower than the 5.4% of providers that responded to the survey in 2017. In their provider satisfaction report, the MCO notes the following ways in which they intend to improve participation going forward: 1. Implement a provider email alert that will increase provider awareness of the provider satisfaction survey. 2. Articles will be published in the summer and fall provider newsletters regarding the upcoming survey, and provider advocates will be provided with the newsletter to hand out at provider meetings. 3. MCO staff and provider advocates will promote the survey during face-to-face provider meetings, webinars, and provider forums. 4. Increase the number of times the survey is sent to providers and expand the timeframe that providers have to return their feedback.	
The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. Provider satisfaction survey report due date: 45 calendar days following 12th month of contract year	**Reports** Provider satisfaction survey results, including follow-up actions taken	Full	Full	This requirement is addressed, per evidence contained within the Provider Survey Results Annual Report. Last year, the MCO identified various drivers that informed their action plans to improve provider satisfaction; these included operational consistency across work units to improve performance of timeliness and communication of appeals, MCO support	

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				services, and ease of working with MCO staff. 2018 survey results demonstrate improved provider satisfaction with the credentialing and appeals processes. UHCCP identified the following areas of opportunity for 2019, based on satisfaction results: 1. Prior Authorization Process 2. Care Management 3. Relationship 4. Customer Service The provider satisfaction survey demographics reflect that the majority of respondents were from independent clinics with five or fewer providers. The provider perception is that time on the phone around prior authorization, care management, and customer service is time-consuming for a small office with limited resources. To improve the overall provider experience in 2019, UHCCP has established the following initiatives: 1. Established a work group that includes focused teams specific to prior authorization, customer service, care management, and relationship. 2. Review comments to understand areas for improvement. 3. Create an action list and implement improvement plan.	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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. Work to improve UnitedHealthcare processes that were identified by the responding providers. 5. Seek input from Clinical Provider Advisory Committee (CPAC) and key provider stakeholders on what they feel the MCO is doing well and where opportunities remain.	
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			
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			
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	Full	This requirement is addressed within the Member Advisory Committee Annual Plan on page 4. This requirement is further evidenced within the MAC meeting minutes.	
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			
The MCO must develop and implement a Member Advisory	**Documents**	Full	Full	This requirement is addressed within the	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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 minimum of 60 calendar days before the contract start date and annually thereafter.	Member Advisory Committee Plan			Member Advisory Committee Annual Plan.	
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	Full	This requirement is evidenced within the MAC meeting minutes and agendas.	
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** Semiannual reports submitted during the review period	Full	Full	This requirement is addressed in the biannual MAC reports submitted to MLTC. The MCO submitted a separate member roster that was attached within the MAC reports.	
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 substance use disorder treatment for adults, children, and adolescents in the State.	**Documents** Clinical Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	Full	This requirement is addressed in the QI Program Description on page 11, and in the CPAC minutes and agendas.	
The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice	**Documents** Agendas and meeting minutes for all committee	Full	Full	This requirement is addressed in the QI Program Description on page 11, and evidenced within the CPAC minutes.	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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, 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.	meetings held during review period				
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			
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	Full	This requirement is addressed in the QI Program Description on page 11, and evidenced within the CPAC 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	Full	This requirement is addressed in the QI Program Description on page 11; the Committee meets a minimum of quarterly. This is further evidenced within the meeting minutes and agendas.	
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 not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.	Onsite discussion	Full	Full	All applicable EQR activities were discussed within the context of the compliance review, which took place May 14, 2019.	
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			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

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Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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 Required for any new subcontractors annually	Full	Full	This requirement is addressed in the UnitedHealthcare Clinical Services Delegated Credentialing Oversight Policy on pages 2–4. The MCO provided a list with 17 active subcontractors. All 17 subcontracts pre-dated the review period and, therefore, the requirement for pre-delegation evaluation was not applicable. The MCO also provided a list of five credentialing delegates, one of which (Sanford Health Plan) was new. The MCO provided a pre-delegation evaluation report for this new credentialing delegate. On site, the MCO confirmed that these credentialing delegates are audited annually and the results are presented to the Clinical and Provider Advisory Committee (CPAC) and then to the Quality Management Committee (QMC). On site, the MCO showed evidence (in the form of meeting minutes) that the results of the credentialing delegate reviews were presented to CPAC on November 27, 2018, and to QMC on March 27, 2019.	
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 Required for any new	Full	Full	UHCCP provided subcontractor agreements (contracts) for the 17 active contractors, all of which met the requirement.	

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Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
	subcontractors annually				
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 follow-up actions taken Also includes reviewer completion of subcontractor worksheet	Full			
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 follow-up actions taken Also includes reviewer completion of subcontractor worksheet	Full			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
MCO: UnitedHealthcare Community Plan

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
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			
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	Full	This requirement is addressed in the UM Program Description, pages 13–15.	
Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.		Full	Full	This requirement is addressed in the UM Program Description, pages 13–14.	
Mechanisms to detect and document over- and under-utilization of medical services.		Full	Full	This requirement is addressed in the UM Program Description, pages 14–15 and 29.	
Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.		Full	Full	This requirement is addressed in the UM Program Description, pages 19–20.	
Availability of UM criteria to providers.		Full	Full	This requirement is addressed in the UM Program Description, page 26.	

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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**	**Prior Determination**	**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**
Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.		Full	Full	This requirement is addressed in the UM Program Description, pages 20–22.	
Availability of physician reviewers to discuss determinations by telephone with physicians who request them.		Full	Full	This requirement is addressed in the UM Program Description, page 13.	
Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.		Full	Full	This requirement is addressed in the UM Program Description, pages 15–16.	
A process and procedures to address disparities in health care.		Full	Partial	This requirement is not found in the UM Program Description. The MCO provided a Health Disparities Plan; however, the requirement explicitly states that disparities in health care must be addressed within the MCO's UM Program Description. **Recommendation** The MCO should include a process and procedures to address disparities in health care in the UM Program Description. **MCO Response** UnitedHealthcare Community Plan has reviewed the recommendation to address disparities in health care in the UM Program Description. The MCO agrees to work with the appropriate individuals to update the UM Program Description as recommended. **IPRO Final Findings** No change in review determination.	
A process for identifying and analyzing clinical issues by		Full	Full	This requirement is addressed in the UM	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
appropriate clinicians and, when necessary, developing corrective actions to improve services.				Program Description, pages 13–14.	
A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR.		Full	Full	This requirement is addressed in the UM Program Description, pages 13–15.	
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	Full	This requirement is addressed in the UM Program Description, pages 11–12.	
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	Full	This requirement is addressed in the UM Program Description, pages 11–12.	
A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 45 calendar days following the 12th month of the contract year.		Full	Full	This requirement is addressed in the UM Program Description, page 31.	
Practice Guidelines The MCO must develop practice guidelines that: Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	**Documents** Policy/procedure List of practice guidelines developed/adopted by MCO	Full			

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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**	**Prior Determination**	**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**
	Examples of practice guidelines				
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			
Are adopted in consultation with participating health care professionals.	**Documents** Policy/procedure Evidence of participation of health care professionals	Full			
Are reviewed and updated a minimum of annually, as appropriate.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Clinical Review Criteria Policy, page 1.	
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			
Are posted to the MCO's website.	**Documents** Policy/procedure View website onsite	Full			
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			
The MCO must provide affected network providers with technical assistance and other resources to implement the	**Documents** Policy/procedure	Full			

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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**	**Prior Determination**	**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**
practice guidelines.	Evidence of offering/providing technical assistance and other resources				
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 follow-up actions taken	Full	Full	This requirement is addressed in the Clinical Review Criteria policy, page 1.	
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	Full	This requirement is addressed in the QMC and UM Committee meeting agendas and meeting minutes provided. Each contains evidence of state representation and discussion/ approval of clinical practice guidelines.	
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 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			
2. Not require service authorization for emergency services.		Full			
3. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the		Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
services that are delivered can be reasonably expected to achieve their purpose.					
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			
5. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.	**Reports** Also includes evidence of monitoring, including results and follow-up actions taken	Full			
6. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.		Full			
7. Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth.		Full			
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			
9. Consult with the requesting network provider, when appropriate.	**Onsite File Review** Also includes UM file review results	Full			
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			

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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**	**Prior Determination**	**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**
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			
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: 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.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full			
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			
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			
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 follow-up actions taken	Full			

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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**	**Prior Determination**	**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**
5. Provider reviews related to Medicaid compliance issues.	**Documents** Policy/procedure Example of a provider review related to compliance	Full			
6. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.	**Documents** Policy/procedure	Full			
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 follow-up actions taken	Full			
The MCO must monitor for potential off-label drug usage.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full			
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 follow-up actions taken	Full			
Utilization Management Committee The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its	**Documents** UM Committee description	Full	Full	This requirement is addressed in the NMCMC meeting minutes during the review period and agendas provided by the	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-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.	List of membership Agendas and meeting minutes for all committee meetings held during review period **Reports** UM reports for review period UM Program Evaluation			MCO.	
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			
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			
Notice of Adverse Action	**Documents**	Full			

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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**	**Prior Determination**	**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 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.	Policy/procedure Template notice of action				
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			
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			
2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
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			
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review**	Full			

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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**	**Prior Determination**	**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**
	UM file review results				
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			
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
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			
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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			

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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**	**Prior Determination**	**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**
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.]					
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			

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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**	**Prior Determination**	**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**
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			
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			
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,	**Documents** Policy/procedure **Onsite File Review**	Full	Full	This requirement is addressed in the Initial Review Timeframes Policy, page 6. File Review Results	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**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**
maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The 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.	UM file review results			Of the five expedited UM files reviewed, all five files met the requirement.	
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			