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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2024–2025 External Quality Review Technical Report

for

Heritage Health Program

This report was produced for the Division of Medicaid and Long-Term Care by Health Services Advisory Group, Inc.

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1. Executive Summary

Background

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) for administering Medicaid and Children's Health Insurance Program (CHIP) programs, to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCOs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1] with further revisions released in November 2020.[2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

Heritage Health Program

The Nebraska Medicaid Managed Care Program, Heritage Health, combines Nebraska MLTC's physical health, behavioral health, dental, and pharmacy programs into a single comprehensive and coordinated program for the State's Medicaid and CHIP members. In 2022, DHHS issued a request for proposals (RFP) to select qualified bidders for the Heritage Health contract. The 2022 RFP included several changes: integrating dental services with physical health, behavioral health, and pharmacy services; simplifying credentialing for providers; and improving electronic visit verification. The RFP also required the MCOs to have a highly integrated dual-eligible special needs plan (HIDE-SNP) in place in order to serve members who are eligible for both Medicare and Medicaid under a single MCO. Two incumbent MCOs were selected, along with one new contractor. Beginning on January 1, 2024, the Heritage Health program included **Molina Healthcare of Nebraska** (**Molina**), **Nebraska Total Care** (**NTC**), and **United Healthcare Community Plan** (**UHCCP**), which serves all Medicaid and CHIP members statewide under 1915(b) authority. The current contracts are full-risk, capitated managed care contracts.

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[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Feb 5, 2025.

[2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 5, 2025.

During calendar year 2024, DHHS used the exemption option allowed under 42 CFR §438.362 to exempt **UHCCP**'s and **NTC**'s HIDE-SNP plans from EQR. The beginning date of the current exemption period is January 1, 2024, and ends December 31, 2025.

The MCOs contracted with DHHS are displayed in Table 1-1. The table also displays their NCQA Accreditation Status, along with enrollment totals as of February 2024.[3]

Table 1-1—Heritage Health MCOs

MCO	Services Provided	NCQA Accreditation Status	Total Members
Molina	Physical and behavioral health care, pharmacy services, and dental services	Interim[4] through November 24, 2025	105,923
NTC	Physical and behavioral health care, pharmacy services, and dental services	Accredited[5] through February 25, 2025 Health Equity Accredited[6] through November 30, 2025	118,855
UHCCP	Physical and behavioral health care, pharmacy services, and dental services	Accredited through July 19, 2026	118,712

Scope of External Quality Review

In contract year (CY) 2024–2025, HSAG conducted the mandatory EQR-related activities. The mandatory activities conducted were:

- **Validation of performance improvement projects (PIPs) (Protocol 1).** HSAG validated the ongoing PIPs through an independent review process. In its PIP evaluation and validation, HSAG used Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[7] HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.
- **Validation of performance measures—HEDIS methodology (Protocol 2).** As set forth in 42 CFR §438.358, HSAG conducted the validation of performance measures activity in compliance with the

[3] Nebraska Department of Health and Human Services. Heritage Health Public Dashboard Data, March 6, 2024. Available at: https://dhhs.ne.gov/Documents/HeritageHealthDashData.pdf. Accessed on: Feb 5, 2025.
[4] Interim is for basic structure and processes in place to meet expectations for consumer protection and quality improvement.
[5] Accredited is for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
[6] Health Equity Accredited is for the delivery of culturally appropriate and quality interventions for service diverse populations.
[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

CMS protocols released in February 2023.[8] Two MCOs—**NTC** and **UHCCP**—underwent an NCQA HEDIS Compliance Audit through an NCQA licensed HEDIS auditor to assess their performance on measures selected by DHHS for review. The HEDIS Compliance Audit also determined the extent to which performance measures calculated by the MCOs followed specifications required by NCQA. HSAG obtained each MCO's HEDIS data and final audit report (FAR) produced by the MCO's HEDIS auditor, and evaluated the data and report to ensure that the HEDIS audit activities were conducted as outlined in the NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.*[9] DHHS awarded a contract to a new MCO—**Molina**—in January 2023. **Molina** began providing health care services to Medicaid beneficiaries in Nebraska on January 1, 2024, and did not undergo a NCQA HEDIS Compliance Audit during the current CY.

- **Assessment of compliance with Medicaid and CHIP managed care regulations (compliance with regulations) (Protocol 3).** As set forth in 42 CFR §438.358, HSAG conducted the compliance with regulations activity in compliance with the CMS protocols released in February 2023.[10] Assessment of compliance with standards was designed to determine the MCOs' compliance with their contracts with DHHS and with State and federal managed care regulations.
- **Validation of network adequacy (Protocol 4).** As set forth in 42 CFR §438.68, HSAG conducted the validation of network adequacy activity in compliance with the CMS protocols released in February 2023, specifically CMS EQR *Protocol 4. Validation of Network Adequacy Performance.*[11] HSAG conducted an evaluation of the MCOs' compliance with Heritage Health contract standards for geographic access to care. HSAG conducted a network capacity analysis, comparing the number of providers in each MCO-contracted provider network to the number of members enrolled with the MCO. In addition, the geographic distribution of the MCOs' contracted providers was evaluated relative to their member populations by calculating the percentage of members with the access to network providers required by the contractual geographic access standards.

For a comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to *Section 3* of this report. Table 1-2 provides HSAG's timeline for conducting each of the EQR activities.

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

[9] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

Table 1-2—Timeline for EQR Activities

Activity	EQRO Protocol	EQR Activity Start Date	EQR Activity End Date
Validation of performance improvement projects	1	April 1, 2024	October 28, 2024
Validation of performance measures—HEDIS methodology	2	April 8, 2024	December 31, 2024
Assessment of compliance with Medicaid and CHIP managed care regulations	3	April 1, 2024	December 12, 2024
Validation of network adequacy	4	April 24, 2024	December 31, 2024

Reader's Guide

Report Purpose and Overview

To comply with federal health care regulations at 42 CFR Part 438, DHHS contracts with HSAG to provide an annual assessment of the performance of the State's Medicaid and CHIP MCOs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that HSAG conducted with the Heritage Health MCOs throughout CY 2024–2025 and is submitted to CMS. The technical report is intended to help the Nebraska Heritage Health Program to:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCO's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance health care delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCOs that it contracts with for services.
- Help the MCOs improve their performance with respect to the quality, timeliness, and accessibility of care.

How This Report Is Organized

Section 1—Executive Summary includes a brief introduction to the Medicaid and CHIP managed care regulations and the authority under which this report must be produced. It also describes Nebraska's Medicaid and CHIP managed care program as well as the scope of the EQR-related activities conducted during CY 2024–2025.

The Executive Summary also includes the Reader's Guide. The Reader's Guide provides the purpose and overview of this EQR annual technical report; an overview of the scope of each EQR activity performed; This section also provides a brief overview of how this report is organized and the definitions for "quality," "timeliness," and "access" used by CMS, NCQA, and HSAG to create this report.

Section 2—Comparative Statewide Results provides statewide comparative results organized by EQR activity, and statewide trends and commonalities used to assess the quality, timeliness, and accessibility of services provided by the MCOs and to derive statewide conclusions and recommendations. This section also includes any conclusions drawn and recommendations identified for statewide performance improvement, as well as an assessment of how DHHS can target goals and objectives of the State's quality strategy to better support the improvement of the quality, timeliness, and accessibility of care provided by the MCOs.

Section 3—Methodology contains the following information for each EQR activity (i.e., validation of PIPs, validation of performance measures [PMV], assessment of compliance with Medicaid managed care regulations [CR], and network adequacy validation [NAV]):

- Objectives
- Technical methods of data collection
- Description of data obtained
- How data were aggregated and analyzed
- How conclusions were drawn
- Information systems (IS) standards review and performance measure results (validation of performance measures only)

This section also describes how HSAG aggregated and analyzed statewide data.

Appendices A–C provide for each MCO an activity-specific presentation of results of the EQR-related activities and an assessment of the quality, timeliness, and accessibility of care and services as applicable to the activities performed and results obtained. These appendices also present activity-specific conclusions and recommendations based on CY 2024–2025 EQR-related activities, as well as follow-up on recommendations made based on the prior year's EQR-related activities. Additionally, a more in-depth explanation of the NCQA IS standards is provided in *Appendix D* of this report and *Appendix E* includes the network adequacy standards.

Definitions

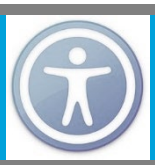
HSAG used the following definitions to evaluate and draw conclusions about the performance of the Medicaid MCOs in each of the domains of quality, timeliness, and access.

Quality

as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]

Timeliness

as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).



Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[2]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] Ibid.

[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

2. Statewide Comparative Results

Validation of Performance Improvement Projects

Results

Table 2-1 summarizes key PIP validation milestones that occurred from April 2024 through October 2024.

Table 2-1—CY 2024-2025 MCO PIP Activities

PIP Activities and Milestones	Dates
The MCOs submitted initial PIP submissions to HSAG for validation	April 26, 2024
HSAG provided initial PIP Validation Tools to the MCOs	June 3, 2024
The MCOs submitted final PIP submissions to HSAG for validation	June 24, 2024
HSAG provided final PIP Validation Tools to the MCOs	August 5, 2024
HSAG provided final PIP reports to the MCOs	October 28, 2024

Table 2-2 summarizes the CY 2024–2025 PIP performance for each MCO. Each MCO conducted a PIP focusing on a topic as directed by DHHS. Table 2-2 also presents the validation status. **Molina**'s contract started January 1, 2024; therefore, **Molina** is not included in the statewide PIP results, statewide conclusions, opportunities for improvement, and recommendations. This information will be reported in next year's annual EQR technical report.

Table 2-2—Statewide PIP Results for MCOs

MCO	PIP Topic	Clinical or Nonclinical Topic	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP	Overall Confidence That the PIP Achieved Significant Improvement
NTC	*Plan All-Cause Readmissions*	Clinical	*High Confidence*	*No Confidence*
NTC	*Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*	Nonclinical	*High Confidence*	*High Confidence*
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	Clinical	*High Confidence*	*High Confidence*
UHCCP	*Improving the Member Experience with the Health Plan's Member Services*	Nonclinical	*High Confidence*	*Moderate Confidence*

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were uniformly captured, reported, and presented, HSAG evaluated the IS capabilities of **NTC** and **UHCCP** for accurate HEDIS reporting. HSAG reviewed the IS capabilities assessments of the MCOs, which were conducted by licensed organizations (LOs) and included in the FARs. The review specifically focused on those system aspects that could have impacted the reporting of the selected HEDIS Medicaid measures.

When conducting HEDIS Compliance Audits, the terms "information system" and "IS" are used broadly to include the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation includes a review of any manual processes that may have been used for HEDIS reporting as well. The LO determined if the MCOs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

In accordance with NCQA's *HEDIS MY 2023 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that the MCOs' IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. The MCOs may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

Table 2-3 provides a summary of the MCOs' key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix D* of this report.

Table 2-3—Summary of MCO's Compliance With IS Standards

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software.	All MCOs were compliant with IS Standard R for data management and reporting. The MCOs had procedures in place so that all data extraction and transformation were accurate and valid. The MCOs had processes for oversight and controls to ensure correct implementation of measure reporting software. Sufficient validation processes were in place, ensuring data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	All MCOs were compliant with IS Standard C for clinical and care delivery data. All MCOs had procedures in place so that all data elements required for HEDIS reporting were completely captured. Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off). • IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. • IS M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	All MCOs were compliant with IS Standard M for Medical Record Review (MRR) processes. Data collection tools used by the MCOs were able to capture all data fields necessary for measure reporting. Sufficient validation processes were in place to ensure data accuracy.
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	All MCOs were compliant with IS Standard A for administrative data. The MCOs validated that data conform with industry standards and measure requirements. The MCOs verified their membership information systems to ensure they appropriately enabled measurement. Adequate validation processes were in place, ensuring data accuracy.

Results for Performance Measures

Table 2-4—Nebraska MCO Performance—CMS Adult and Child Core Set MY 2023

CMS Core Set Measures	NTC	UHCCP
CMS Adult Core Measures Set		
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)		
Use of Pharmacotherapy for Opioid Use Disorder—Total (Rate 1)	59.02%	X
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)		
*Ages 18 to 64**	1.79%	X
*Age 65 and Older **	0.00%	X
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)		
Ages 18 to 64	—	X
Age 65 and Older	—	X
Concurrent Use of Opioids and Benzodiazepines (COB-AD)		
*Ages 18 to 64**	19.33%	X
*Age 65 and Older **	11.54%	X
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)		
Ages 21 to 44: Most or Moderately Effective Contraception—Within 3 Days of Delivery	10.13%	X
Ages 21 to 44: Most or Moderately Effective Contraception—Within 90 Days of Delivery	45.86%	X
Ages 21 to 44: Long-Acting Reversible Method of Contraception (LARC)—Within 3 Days of Delivery	0.83%	X
Ages 21 to 44: LARC—Within 90 Days of Delivery	17.71%	X
CMS Child Core Measures Set		
Developmental Screening in the First Three Years of Life (DEV-CH)		
Children Who Turned 1 Year	27.75%	X
Children Who Turned 2 Years	34.16%	X
Children Who Turned 3 Years	32.28%	X
Total	31.39%	X
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)		
Ages 12 to 17	—	X

CMS Core Set Measures	NTC	UHCCP
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)		
Ages 15 to 20: Most or Moderately Effective Contraception—Within 3 Days of Delivery	3.45%	X
Ages 15 to 20: Most or Moderately Effective Contraception—Within 90 Days of Delivery	58.62%	X
Ages 15 to 20: LARC—Within 3 Days of Delivery	2.07%	X
Ages 15 to 20: LARC—Within 90 Days of Delivery	26.90%	X
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)		
Ages 15 to 20: Were Provided a Most Effective or Moderately Effective Method of Contraception	28.81%	X
Ages 15 to 20: Were Provided a LARC	5.31%	X

* For this indicator, a lower rate indicates better performance
— indicates that the rate is not presented in this report as the measure was not reported by the MCO(s).
X indicates that **UHCCP**'s Core Set measure rates were not independently validated and are not presented in this report.

Table 2-5—Nebraska MCO Performance and Statewide Weighted Averages—HEDIS MY 2023

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Effectiveness of Care Domain: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
Body Mass Index (BMI) Percentile Documentation—Total	71.53% ★	70.56% ★	71.02%
Counseling for Nutrition—Total	64.96% ★★	55.96% ★	60.23%
Counseling for Physical Activity—Total	62.04% ★★	52.07% ★	56.80%
Childhood Immunization Status (CIS)			
Combination 3	68.61% ★★★	74.45% ★★★★★	71.60%
Combination 7	60.58% ★★★★	66.42% ★★★★★	63.57%
Combination 10	42.09% ★★★★	48.18% ★★★★★	45.20%
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, tetanus, diphtheria toxoids and acellular pertussis [Tdap])	74.94% ★★	81.02% ★★★	78.35%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	31.14% ★★	35.52% ★★★	33.60%
Lead Screening in Children (LSC)			
Lead Screening in Children	69.88% ★★★	70.80% ★★★	70.35%
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	63.02% ★★★★	54.99% ★★	58.75%
Chlamydia Screening in Women (CHL)			
Ages 16 to 20 Years	30.29% ★	26.77% ★	28.46%
Ages 21 to 24 Years	44.01% ★	38.53% ★	41.18%
Total	36.24% ★	31.84% ★	33.96%
Colorectal Cancer Screening (COL)			
Ages 46 to 50 Years	29.51% ★★★	35.95% ★★★★★	33.22%
Ages 51 to 75 Years	41.30% ★★	53.38% ★★★★	49.03%
Total	38.15% ★★★	49.59% ★★★★★	45.29%
Effectiveness of Care Domain: Respiratory Conditions			
Appropriate Testing for Pharyngitis (CWP)			
Ages 3 to 17 Years	80.49% ★★	80.98% ★★	80.75%
Ages 18 to 64 Years	74.30% ★★★	75.70% ★★★	75.01%
Ages 65 Years and Older	NA	NA	58.54%
Total	78.78% ★★	79.54% ★★	79.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease [COPD] (SPR)			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.42% ★★	28.67% ★★★★	26.90%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	71.82% ★★★	78.10% ★★★★	76.18%
Bronchodilator	84.53% ★★★	85.16% ★★★	84.97%
Asthma Medication Ratio (AMR)			
Ages 5 to 11 Years	80.16% ★★★	76.03% ★★★	77.88%
Ages 12 to 18 Years	76.67% ★★★★	75.83% ★★★★	76.19%
Ages 19 to 50 Years	73.16% ★★★★★	69.87% ★★★★	71.24%
Ages 51 to 64 Years	80.83% ★★★★★	69.42% ★★★	73.20%
Total	76.50% ★★★★	72.75% ★★★★	74.32%
Effectiveness of Care Domain: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	63.99% ★★	72.51% ★★★★	69.29%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	58.00%
Effectiveness of Care Domain: Diabetes			
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)			
HbA1c Control (<8.0%)	60.58% ★★★	63.02% ★★★★	62.10%
*HbA1c Poor Control (>9.0%)**	27.25% ★★★★	29.44% ★★★★	28.61%
Blood Pressure Control for Patients With Diabetes (BPD)			
Blood Pressure <140/ 90 mm Hg	76.16% ★★★★	79.56% ★★★★★	78.28%
Eye Exam for Patients With Diabetes (EED)			
Eye Exam	56.20% ★★★	65.94% ★★★★★	62.26%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Effectiveness of Care Domain: Behavioral Health			
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	62.91% ★★★	65.90% ★★★	64.52%
Effective Continuation Phase Treatment	44.41% ★★★	47.79% ★★★	46.23%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)			
Initiation Phase	47.19% ★★★	44.02% ★★	45.48%
Continuation and Maintenance Phase	53.82% ★★★	48.20% ★★	50.69%
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up—Ages 6 to 17 Years	70.62% ★★★★★	54.46% ★★★	62.23%
30-Day Follow-Up—Ages 6 to 17 Years	84.94% ★★★★★	77.57% ★★★	81.12%
7-Day Follow-Up—Ages 18 to 64 Years	45.66% ★★★★	41.52% ★★★	43.46%
30-Day Follow-Up—Ages 18 to 64 Years	62.15% ★★★	60.55% ★★★	61.30%
7-Day Follow-Up—Ages 65 Years and Older	NA	13.33% ★	17.65%
30-Day Follow-Up—Ages 65 Years and Older	NA	46.67% ★★	50.00%
7-Day Follow-Up—Total	52.15% ★★★★	44.24% ★★★	47.94%
30-Day Follow-Up—Total	68.10% ★★★	64.52% ★★★	66.20%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
7-Day Follow-Up—Total	40.22% ★★★	38.82% ★★★	39.46%
30-Day Follow-Up—Total	58.57% ★★★	60.61% ★★★	59.68%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Follow-Up After High-Intensity Care for Substance Use Disorder [SUD] (FUI)			
7-Day Follow-Up—Total	26.94% ★★	26.61% ★★	26.78%
30-Day Follow-Up—Total	44.08% ★★	44.39% ★★	44.23%
Follow-Up After Emergency Department Visit for Substance Use (FUA)			
7-Day Follow-Up—Total	26.23% ★★★	21.57% ★★	23.79%
30-Day Follow-Up—Total	41.65% ★★★	36.20% ★★★	38.81%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.65% ★★★★	82.20% ★★★	83.24%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)			
Diabetes Monitoring for People with Diabetes and Schizophrenia	73.74% ★★★	75.61% ★★★★	75.04%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)			
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	77.14% ★★	74.00%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.79% ★★★	75.08% ★★★★★	70.95%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose—1 to 11 Years	47.58% ★★★	41.65% ★★	44.42%
Blood Glucose—12 to 17 Years	60.95% ★★	55.05% ★	57.62%
Blood Glucose—Total	55.99% ★★	50.48% ★	52.94%
Cholesterol—1 to 11 Years	34.95% ★★★	30.12% ★★	32.37%
Cholesterol—12 to 17 Years	39.52% ★★	34.47% ★★	36.66%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Cholesterol—Total	37.82% ★★★	32.99% ★★	35.14%
Blood Glucose and Cholesterol—1 to 11 Years	31.99% ★★★	27.29% ★★	29.49%
Blood Glucose and Cholesterol—12 to 17 Years	37.62% ★★	32.16% ★	34.53%
Blood Glucose and Cholesterol—Total	35.53% ★★	30.50% ★★	32.74%
Effectiveness of Care Domain: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)			
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.45% ★★	0.25% ★★★	0.34%
Appropriate Treatment for Upper Respiratory Infection (URI)			
Ages 3 Months to 17 Years	89.12% ★	89.88% ★	89.51%
Ages 18 to 64 Years	79.21% ★★	79.98% ★★★	79.62%
Ages 65 Years and Older	78.13% ★★★	59.32% ★	63.33%
Total	87.01% ★★	87.52% ★★	87.27%
Use of Imaging Studies for Low Back Pain (LBP)			
Total	71.89% ★★★	70.11% ★★	70.93%
Use of Opioids at High Dosage (HDO)			
*Use of Opioids at High Dosage (Average Morphine Milligram Equivalent Dose [MME] ≥90)**	1.53% ★★★	3.84% ★★★	2.99%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Ages 3 Months to 17 Years	73.63% ★★★	77.02% ★★★	75.34%
Ages 18 to 64 Years	36.62% ★	39.53% ★★	38.20%
Ages 65 Years and Older	NA	23.08% ★	26.67%
Total	63.49% ★★★	64.78% ★★★	64.16%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Access/Availability of Care Domain			
Initiation and Engagement of SUD Treatment (IET)			
Initiation of SUD Treatment—Total—Ages 13 to 17 Years	30.14% ★	28.12% ★	29.10%
Engagement of SUD Treatment—Total—Ages 13 to 17 Years	16.90% ★★★★	14.32% ★★★	15.57%
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	36.43% ★	37.51% ★	36.97%
Engagement of SUD Treatment—Total—Ages 18–64 Years	10.20% ★★	11.52% ★★	10.86%
Initiation of SUD Treatment—Total—Ages 65 Years and older	NA	39.75% ★★	40.32%
Engagement of SUD Treatment—Total—Ages 65 Years and older	NA	3.73% ★★	3.23%
Initiation of SUD Treatment—Total—Total	35.85% ★	36.65% ★	36.26%
Engagement of SUD Treatment—Total—Total	10.80% ★★	11.46% ★★	11.14%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	77.62% ★	86.37% ★★★	82.10%
Postpartum Care	76.89% ★★	81.51% ★★★	79.25%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Ages 1 to 11 Years	56.95% ★★	46.74% ★★	51.34%
Ages 12 to 17 Years	65.24% ★★★	53.72% ★★	58.79%
Total	61.98% ★★★	51.04% ★★	55.90%
Utilization and Risk Adjusted Utilization Domain: Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	71.10% ★★★★★	66.40% ★★★★	68.75%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	73.38% ★★★★	69.43% ★★★	71.32%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Ambulatory Care (Per 1,000 Member Years) (AMB)			
*Emergency Department Visits—Total**	611.97 ★★★	545.60 ★★	575.73
Outpatient Visits, Including Telehealth—Total	4,273.13 NC	4,143.82 NC	4,202.52
Inpatient Utilization—General Hospital/Acute Care (IPU)[1]			
Discharges per 1,000 Member Years—Total Inpatient—Total	66.52 NC	66.43 NC	66.47
Average Length of Stay—Total Inpatient—Total	5.24 NC	5.46 NC	5.36
Discharges per 1,000 Member Years—Maternity—Total	35.94 NC	27.76 NC	31.44
Average Length of Stay—Maternity—Total	2.73 NC	2.42 NC	2.58
Discharges per 1,000 Member Years—Surgery—Total	16.24 NC	15.55 NC	15.86
Average Length of Stay—Surgery—Total	9.39 NC	9.38 NC	9.39
Discharges per 1,000 Member Years—Medicine—Total	26.29 NC	32.09 NC	29.45
Average Length of Stay—Medicine—Total	4.97 NC	5.34 NC	5.19
Child and Adolescent Well-Care Visits (WCV)			
Ages 3 to 11 Years	53.48% ★	51.48% ★	52.44%
Ages 12 to 17 Years	56.42% ★★★	56.41% ★★★	56.42%
Ages 18 to 21 Years	26.37% ★★	24.75% ★★	25.48%
Total	50.54% ★★	49.09% ★★	49.76%
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization			
Plan All-Cause Readmissions (PCR)			
*Observed Readmissions—18–64**	11.76% NC	9.23% NC	10.57%

HEDIS Measures	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
*Expected Readmissions—18–64**	10.34% NC	10.85% NC	10.58%
*Observed to Expected (O/E) Ratio—18–64**	1.1380 ★	0.8506 ★★★★	0.9992
Measures Reported Using ECDS			
Breast Cancer Screening (BCS-E)			
Breast Cancer Screening	56.96% ★★★	62.28% ★★★★	60.46%
Prenatal Depression Screening and Follow-Up (PND-E)			
Depression Screening	0.61% ★★	18.88% ★★★★	9.67%
Follow-Up on Positive Screen	NA	NA	NA
Postpartum Depression Screening and Follow-Up (PDS-E)			
Depression Screening	0.43% ★★	6.05% ★★★	3.30%
Follow-Up on Positive Screen	NA	NA	NA

[1] In the *Utilization* domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for information only.
* For this indicator, a lower rate indicates better performance.
NA indicates that the MCO(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2023 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
HEDIS MY 2023 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Assessment of Compliance With Medicaid Managed Care Regulations

In CY 2024–2025 (review period), HSAG reviewed seven of the 13 standards (part 438 Subpart D and QAPI) with which MCOs are required to comply pursuant to 42 CFR Part 438. To assist Nebraska's Medicaid and CHIP MCOs with understanding the Medicaid and CHIP managed care regulations, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. MCOs demonstrating less than 100 percent compliance must develop a corrective action plan (CAP) to address each requirement found to not exhibit full compliance. Table 2-6 delineates the compliance monitoring results for each MCO as well as the standards that were reviewed during the current three-year compliance review cycle. CAPs from findings during the CY 2023–2024 compliance reviews were evaluated and resolved in 2024.

Results

Table 2-6—MCO Compliance Monitoring Results for CY 2024–2025

Standard Number and Title*	Molina**	NTC**	UHCCP**
Standard I—Enrollment and Disenrollment			
Standard II—Member Rights and Confidentiality	66.7%	100%	100%
Standard III—Member Information	86.4%	100%	95.5%
Standard IV—Emergency and Poststabilization Services	100%	100%	100%
Standard V—Adequate Capacity and Availability of Services			
Standard VI—Coordination and Continuity of Care	100%	100%	100%
Standard VII—Coverage and Authorization of Services	84.2%	100%	94.7%
Standard VIII—Provider Selection and Program Integrity			
Standard IX—Subcontractual Relationships and Delegation			
Standard X—Practice Guidelines	100%	100%	100%
Standard XI—Health Information Systems			
Standard XII—Quality Assessment and Performance Improvement			
Standard XIII—Grievance and Appeal System	92.0%	92.0%	100%
Totals	**89.6%**	**97.9%**	**97.9%**

* Bold text indicates standards that HSAG reviewed during CY 2024–2025.
**Grey shading indicates standards that were not reviewed during CY 2024–2025.

Validation of Network Adequacy

Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires states that choose to use managed care plans to set standards for adequate provider networks, and to have a qualified external quality review organization (EQRO) perform an annual EQR of each plan that includes NAV.[12] DHHS contracted HSAG to conduct a NAV during EQR CY 2024–2025. The purpose of this study was to evaluate the extent to which the MCOs are complying with geographic access standards outlined in their contracts. As guided by the CMS EQR Protocol 4, HSAG (1) validated the data and methods that the MCOs used to assess network adequacy, (2) validated the results and generated a validation rating, and (3) is reporting the validation findings in this annual EQR technical report, using the methodologies approved by DHHS.

In collaboration with DHHS, HSAG designed and conducted the following activities to assess the adequacy of the MCOs' compliance with program and contract standards for geographic access to care:

- **Information Systems Capabilities Assessment (ISCA)**: In accordance with CMS EQR Protocol 4, HSAG conducted a desk review of materials that the MCOs submitted, supplemented with live virtual review sessions demonstrating the information systems, data processing procedures, and underlying methodology that the MCOs used to support their network adequacy indicator reporting. This review examined the MCOs' data, methods, and reporting of DHHS' Time and Distance (geographic standards) and Access and Availability Standards.
- **Time and Distance (i.e., Geographic Network Distribution) Analysis**: HSAG evaluated the geographic distribution of the MCOs' contracted providers relative to their member populations. The MCOs are contractually obligated to maintain a provider network accessible to 100 percent of Heritage Health members (unless otherwise specified), within time and distance standards established by DHHS. For most provider categories, the standard requires a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier). For hospitals, all members statewide must have a hospital within 30 minutes of travel time. For each MCO, HSAG calculated the percentage of members with the required access to network providers to evaluate whether the MCO met the time and distance standards. In addition, HSAG calculated the average travel time (minutes) and distance (miles) from each member to the nearest two providers for each MCO and provider category for informational purposes only.
- **Network Capacity Analysis:** HSAG compared the number of providers in each MCO-contracted provider network to the number of members enrolled with each MCO. This provider-to-member ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a provider network to deliver services to Medicaid members. Generally, a lower ratio is more favorable for members, results in less competition for access to providers' limited availability and attention. The ratios are providers here for informational purposes only.

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 13, 2025.

HSAG synthesized the results of these studies to arrive at validation ratings following the methodology defined by CMS.

Results

Aggregated ISCA and NAV Results

This section presents an overview of the ISCA and NAV results for CY 2024–2025, with data collected as of June 1, 2024. Results are presented in two sections: the Network Adequacy Validation Results and the Time and Distance Analysis.

Network Adequacy Validation Results

HSAG completed an ISCA for each of the three MCOs and presented the ISCA findings and assessment of any concerns related to data sources used in the NAV. HSAG conducted a desk review of materials that the MCOs submitted, supplemented with live virtual review sessions demonstrating the information systems, data processing procedures, and underlying methodology that the MCOs used to support their network adequacy indicator reporting.

HSAG prepared and submitted a document request packet to each MCO outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCOs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents that HSAG requested included an Information Systems Capabilities Assessment Tool (ISCAT), a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the MCOs, such as network data files or directories and member enrollment files, through a single documentation request packet that HSAG provided to each MCO.

HSAG hosted an MCO-wide webinar focused on providing technical assistance to the MCOs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines. HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

All three MCOs cooperated fully with the ISCA process and provided HSAG with the requested documentation and access to their information systems. After reviewing documentation of their methodologies, HSAG confirmed in virtual review sessions that the MCOs used geospatial analysis software to conduct time and distance studies. HSAG confirmed that the MCOs conducted regular surveys to monitor appointment availability, discussed their methodologies for selecting survey samples, and observed how they captured and preserved survey results.

HSAG compared the MCOs' submitted quarterly GeoAccess reports to the results of its independent time and distance study. Across all MCOs, the time and distance results submitted to DHHS matched the HSAG-calculated results within reasonable margins.

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that the MCOs used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-7 summarizes HSAG's validation ratings for the three MCOs by indicator type.

Table 2-7—Summary of NAV Ratings by MCO and Type of Network Adequacy Indicator

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Molina				
Time and Distance	100%	0%	0%	0%
Access and Availability	100%	0%	0%	0%
NTC				
Time and Distance	100%	0%	0%	0%
Access and Availability	100%	0%	0%	0%
UHCCP				
Time and Distance	100%	0%	0%	0%
Access and Availability	100%	0%	0%	0%

Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has *High Confidence* in the MCOs' data systems, methodologies, and the accuracy and reliability of their reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, provider data systems, methodologies, or results for any of the MCOs. The results of each MCO's validation scoring are presented in greater detail in its MCO-specific appendix.

Time and Distance Analysis

This section will present an overview of the results for HSAG's independent calculation of each MCO's performance on the geographic access standards for most providers in terms of distance in miles, apart from the Hospitals provider category, for which the standard is defined in terms of time in minutes.

Table 2-8 presents the number of eligible members used to calculate the geographic distribution analyses and provider-to-member ratios for each MCO as of June 1, 2024. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to

children, defined as members 18 years of age and younger.[13] Analyses for obstetrics and gynecology (OB/GYN) were limited to female members 15 years of age and older.

Table 2-8—Statewide Member Enrollment and Demographics by MCO

Member Population	Molina	NTC	UHCCP
Children 18 Years and Younger	55,448	60,326	59,490
Females 15 Years and Older	36,647	41,247	39,638
All Members*	109,631	116,341	113,929

*All Members will not equal the sum of Children 18 Years and Under and Females 15 Years and Older as the latter categories overlap and do not include adult males. In addition, All Members includes members whose age was not known.

Table 2-9 displays the percentage of each MCO's members with access to providers within the geographic access standards established by DHHS. Findings are stratified by provider category and urbanicity, where applicable. Results are reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results are reported statewide.

Table 2-9—Percentage of Members With Required Access to Care by Provider Category and MCO

Provider Category	Molina	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
PCP, Urban	>99.9%	100.0%	>99.9%
PCP, Rural	>99.9%	100.0%	100.0%
PCP, Frontier	100.0%	100.0%	100.0%
High-Volume Specialists**			
Cardiology	>99.9%	>99.9%	>99.9%
Neurology	100.0%	100.0%	99.9%
OB/GYN	>99.9%	>99.9%	99.8%
Oncology-Hematology	99.8%	100.0%	99.5%
Orthopedics	100.0%	100.0%	100.0%
Pharmacy, Urban***	96.6%	95.9%	95.9%
Pharmacy, Rural***	93.8%	92.6%	91.2%

[13] DHHS has used the term "pedodontist" in the Geographic Access Standards template and the term "pediadontist" in its current network adequacy standards. Both terms are intended to include specialists with taxonomies identifying them as pediatric dentists. HSAG has used the term "pediadontist" in this report to align with the standards established by DHHS.

Provider Category	Molina	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
Pharmacy, Frontier***	98.2%	97.7%	97.3%
All Behavioral Health Inpatient and Residential Service Providers, Urban	100.0%	100.0%	97.3%
All Behavioral Health Inpatient and Residential Service Providers, Rural	100.0%	100.0%	92.6%
All Behavioral Health Inpatient and Residential Service Providers, Frontier	100.0%	100.0%	70.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Urban	>99.9%	>99.9%	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Rural	>99.9%	99.8%	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	98.6%	97.6%	98.0%
Hospitals	97.5%	88.3%	97.3%
Optometry, Urban	95.3%	>99.9%	>99.9%
Optometry, Rural	85.9%	>99.9%	>99.9%
Optometry, Frontier	75.8%	100.0%	100.0%
Ophthalmology, Urban	97.5%	97.9%	98.0%
Ophthalmology, Rural	100.0%	100.0%	>99.9%
Ophthalmology, Frontier	100.0%	100.0%	90.7%
Dental			
Dentist, Urban	100.0%	100.0%	100.0%
Dentist, Rural	100.0%	99.9%	99.9%
Dentist, Frontier	100.0%	100.0%	100.0%
Dental Specialists			
Oral Surgeon, Urban	92.3%	91.3%	66.5%
Oral Surgeon, Rural	70.1%	70.8%	58.5%
Oral Surgeon, Frontier	18.5%	26.1%	20.9%
Orthodontist, Urban	81.8%	84.4%	79.2%
Orthodontist, Rural	56.1%	67.3%	45.2%
Orthodontist, Frontier	84.6%	100.0%	32.5%
Periodontist, Urban	58.5%	97.8%	76.1%

Provider Category	Molina	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
Periodontist, Rural	18.7%	78.7%	36.8%
Periodontist, Frontier	0.0%	85.8%	0.0%
Pediadontist, Urban	99.4%	—	93.6%
Pediadontist, Rural	84.7%	—	73.6%
Pediadontist, Frontier	83.7%	—	85.6%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity.
"—" indicates the MCO did not submit data for this provider type.
*The minimum access is required for 100 percent of members unless otherwise noted.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.
***For pharmacies, the standard must be met for 90 percent of members within urban counties, or 70 percent of members in rural and frontier counties.

Overall Heritage Health Program Conclusions

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw statewide conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Nebraska's CY 2024–2025 technical report, HSAG performed the following steps:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each MCO to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and accessibility of care and services furnished by the MCO.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, quality, timeliness, and accessibility of care and services furnished by the MCO.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Table 2-10 provides the overall strengths and opportunities for improvement of the Heritage Health Program that were identified as a result of the EQR activities.

Table 2-10—Overall Heritage Health Program Conclusions: Quality, Timeliness, and Access

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
Quality	PIP	The two MCOs, **NTC** and **UHCCP**, reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs.
Quality	PIP	The two MCOs followed methodologically sound designs for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time.
Quality	PIP	The two MCOs conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers.
Quality, Timeliness, and Access	PMV	The *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10*; *Lead Screening in Children*; and *Colorectal Cancer Screening—Ages 46 to 50 Years* and *Total* measure indicators were a strength for the two MCOs. Both MCOs ranked at or above NCQA's Quality Compass national Medicaid Health Maintenance Organization (HMO) HEDIS MY 2023 75th percentile benchmark for the *Childhood Immunization Status—Combination 7* and *Combination 10* measure indicators. Both MCOs ranked at or above NCQA's Quality Compass

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
		national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Childhood Immunization Status—Combination 3* measure indicator, the *Lead Screening in Children* measure, and the *Colorectal Cancer Screening—Ages 46 to 50 Years* and *Total* measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. In addition, the *Lead Screening in Children* rates demonstrate that children under 2 years of age were adequately receiving a lead blood testing to ensure they were maintaining limited exposure to lead. The *Colorectal Cancer Screening—Ages 46 to 50 Years* and *Total* rates demonstrate that members were receiving recommended preventative screenings.
Quality and Timeliness	PMV	The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the following measure indicators: • *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years* • *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* • *Asthma Medication Ratio—Ages 5 to 11 Years, Ages 12 to 18 Years, Ages 19 to 50 Years, Ages 51 to 64 Years,* and *Total*
Quality, Timeliness, and Access	PMV	The *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years* rates demonstrate that providers affiliated with both MCOs were appropriately prescribing antibiotics and ordering a group A streptococcus test for pharyngitis episodes. The *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* rates demonstrate that both MCOs were effectively managing the pharmacotherapy treatments for their members with COPD. Finally, the *Asthma Medication Ratio* rates for these measure indicators demonstrate that the two MCOs were effectively managing this treatable condition for members with persistent asthma.
Quality and Timeliness	PMV	The *Controlling High Blood Pressure* measure was a strength for one MCO that ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for this measure. The rate for this measure demonstrates that the MCO was effective in helping members manage their blood pressure, reducing their risk for heart disease and stroke.

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
Quality	PMV	The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *Blood Pressure Control for Patients With Diabetes* measures were a strength for both MCOs. The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for both measures. Both MCOs also ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Eye Exam for Patients With Diabetes* measures. The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* and *Blood Pressure Control for Patients With Diabetes* rates demonstrate that both MCOs were effective in helping adult members with diabetes adequately control their blood pressure. In addition, the *Eye Exam for Patients With Diabetes* rates demonstrate that both MCOs were effective in ensuring that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease.
Quality, Timeliness, and Access	PMV	The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the following measure indicators: • *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17 Years, Ages 18 to 64 Years, and Total) and 30-Day Follow-Up (Ages 6 to 17 Years, Ages 18 to 64 Years, and Total)* • *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total* • *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • *Diabetes Monitoring for People with Diabetes and Schizophrenia* • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
Quality	PMV	The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* rates demonstrate that both MCOs were effective in partnering with providers to ensure that members with a diagnosis of major depression were treated with antidepressant medications and remained on the medication treatment plan to properly manage their condition.

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
Quality, Timeliness, and Access	PMV	The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that both MCOs were effective in ensuring the members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* rates demonstrate that MCOs properly managed care for patients discharged after an emergency department (ED) visit for mental illness and for substance use, as they are vulnerable after release.
Quality, Timeliness, and Access	PMV	Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People with Diabetes and Schizophrenia* rates demonstrate that both MCOs were effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population.
Quality and Access	PMV	The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rates demonstrate that the two MCOs were effective in partnering with providers to ensure that members with schizophrenia or schizoaffective disorder were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
Quality	PMV	The *Use of Opioids at High Dosage* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* measure indicators were a strength for both MCOs. The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for these measure indicators. The rates for *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* indicate that the two MCOs effectively prevented or minimized the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. The *Use of Opioids at High Dosage* rate indicate that the two MCOs effectively prevented or minimized the prescribing of opioids at a dosage of ≥90 mg morphine equivalent dose.
Quality, Timeliness, and Access	PMV	The *Engagement of SUD Treatment—Total—Ages 13 to 17 Years* measure indicator was a strength for both MCOs. The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for this measure indicator. The rate for this measure indicator demonstrates that the two MCOs effectively engaged members with a new substance use disorder (SUD) episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment.

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
Quality and Access	PMV	The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits,* and *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicators were a strength for both MCOs. The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for this measure indicator. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates demonstrate that the MCOs were effective in ensuring that children were seen by a primary care provider (PCP) to assess and influence members' early development. The *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator rate indicates that the two MCOs were effective in ensuring that adolescents received appropriate well-care visits to provide screening and counseling.
Quality	PMV	The *Breast Cancer Screening* measure was a strength for both MCOs. The two MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for this measure indicator. The rate for this measure indicator demonstrates that the two MCOs were effective in ensuring that women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years.
Quality, Timeliness, and Access	CR	All three MCOs achieved 100 percent compliance for three standards during CY 2024–2025.
Timeliness and Access	CR	All three MCOs achieved 100 percent compliance for the Emergency and Poststabilization Services standard, demonstrating that each MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
Quality, Timeliness, and Access	CR	All three MCOs achieved 100 percent compliance for the Coordination and Continuity of Care standard, demonstrating the MCOs had adequate processes in place for their care management programs.
Quality	CR	All three MCOs achieved 100 percent for the Practice Guidelines standard, demonstrating the MCO had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review.
Quality, Timeliness, and Access	CR	All three MCOs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to their Medicaid members. MCO-specific strengths, opportunities for improvement, and required actions are detailed in *appendices A–C.*

Overall Program Strengths		
Domain	**Related EQR Activity**	**Conclusions**
Access	NAV	Overall, the MCOs performed well. HSAG has *High Confidence* in the MCO-reported data, methods, results, and reporting. The time and distance study confirmed that the MCOs met the quantitative standards the State has set for ensuring that the provider networks are adequate in number and location to meet the needs of 100 percent or slightly fewer of their Medicaid members.
Access	NAV	This is the first year in which dental services have been integrated into the three MCO contracts rather than provided by an independent dental benefits manager, as in past years. The MCOs demonstrated varying degrees of success at meeting the time and distance standards for these new provider and service types, especially those governing dental specialists.
Access	NAV	Overall, the CY 2024–2025 NAV results suggest that Nebraska's MCOs have generally contracted with a variety of providers to ensure that members have access to a broad range of health care services within the State's geographic time and distance standards. The results of the ratio and average distance to the two nearest providers also provide evidence of the strength of the MCOs' provider networks.

Overall Program Opportunities for Improvement		
Domain	**Related EQR Activity**	**Conclusions**
Quality	*PIP*	**NTC** reported indicator results for the clinical PIP that demonstrated a decline in performance from baseline to Remeasurement 3.
Quality	PMV	MCOs ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for the following measure indicators: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* • *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total*
Quality	PMV	Monitoring the weight of children and adolescents can reduce the risk for obesity and prevent adverse health outcomes. Additionally, screening adolescent and adult women can help identify chlamydia infections which, if untreated, can lead to serious and irreversible complications, including pelvic inflammatory disease (PID), infertility, and increased risk of becoming infected with human immunodeficiency virus-1 (HIV-1).

Overall Program Opportunities for Improvement		
Domain	**Related EQR Activity**	**Conclusions**
Quality	PMV	The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for both MCOs. The two MCOs' rates for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. The rates for this measure indicator show that a diagnosis of URI resulted in an antibiotic dispensing event for more members in comparison to the national benchmark. The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance.
Quality, Timeliness, and Access	PMV	The *Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators were a weakness for both MCOs. The two MCOs' rates for these measure indicators ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark.
Quality and Access	PMV	The *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* measure indicator was a weakness for both MCOs. The two MCOs' rates for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. Well-care visits provide an opportunity for providers to provide screening and counseling.
Access	CR	Two out of the three MCOs received 95.5 percent or less for the Member Information standard, indicating that members may not be receiving information regarding their benefits, rights, and protections.
Access	CR	One out of three MCOs received 66.7 percent for the Member Rights and Confidentiality standard, indicating members may not be receiving timely and adequate access to information that can assist them in accessing care and services.
Timeliness and Access	CR	Two out of the three MCOs received 94.7 percent or less for the Coverage and Authorization of Services standard, demonstrating that the MCO may not have an effective system to review, approve, or deny authorization requests, and may not be consistently applying the medical necessity criteria.
Access	NAV	The MCOs have an opportunity for improvement in increasing statewide access to dental specialists and access to behavioral health outpatient assessment and treatment providers in Behavioral Health Region 2 and to a lesser extent in Region 4.

Nebraska DHHS Quality Strategy for Heritage Health Program

In accordance with 42 CFR §438.340, DHHS implemented a written quality strategy for assessing and improving the quality of health care services furnished by the MCOs to Nebraska Medicaid members under the Heritage Health Program.

MLTC engages with all contracted MCOs to support their quality initiatives and to help align these interventions with those described in the quality strategy. MLTC staff provide continuous quality oversight and contract management of the MCOs by participating in regularly scheduled meetings to discuss topics such as barriers to quality improvement, population-based initiatives, and meetings to consult on difficult-to-place patients, high-cost claimants, and medically/behaviorally complex patients. MLTC performs in-depth compliance oversight to ensure that contractual standards for its programs are maintained in the delivery of services to Nebraska's Medicaid managed care members.

MLTC's goals and objectives for improving the quality of the Heritage Health Program have not changed significantly over time, but within the updated quality strategy, the goals are now tied to a system by which the success of focused interventions can be measured. With this improved structure, moving forward, MLTC will perform effectiveness evaluations in order to continually improve the quality strategy and to make updates when evaluations point toward an approach that may be more impactful on quality improvement. MLTC will annually review all quality metrics in order to assess progress toward performance targets.

Goals and Objectives

The goals and objectives for the Heritage Health Program, described in Table 2-11, directly reflect the Quadruple Aim of improving member experience of care, provider experience of care, and the health of populations, as well as ensuring the long-term financial viability of the Medicaid program.

Table 2-11—Goals and Objectives of Heritage Health Program

Aim	Goal	Objective
Improve the Member Experience of Care 	Enhance integration of services and whole person care.	Integrate dental care into Heritage Health contracts.
		Update non-emergency medical transportation regulations to allow for additional transportation flexibility.
	Expand access to high-quality services to meet the needs of diverse clients.	Update telehealth regulations to improve access to care.
		Ensure timely access to primary and specialty care.
	Improve coordination of care.	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management.
	Increase member satisfaction.	Engage with enrollees to improve enrollee experience and outcomes and increase public awareness about services.

Aim	Goal	Objective
Improve the Provider Experience of Care 	Timely decision making.	Ensure timely payment for claims.
		Resolve appeals in a timely manner.
	Increase provider satisfaction.	Streamline provider credentialing by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialing verification subcontractor.
	Build transparent and trusting stakeholder relationships.	Conduct regular "listening sessions" where relevant MLTC leadership meet with provider and community constituents at least quarterly to solicit their ideas, suggestions, and feedback for incorporation into policies and program improvements when/where possible.
Improve the Health of Populations 	Promote wellness and prevention.	Improve screening rates for cancers.
		Promote oral health.
		Ensure access to care during pregnancy, childbirth, and postpartum.
		Promote healthy development and wellness in children and adolescents.
		Improve immunization rates.
		Ensure appropriate use of prescription drugs.
	Improve chronic disease management and control.	Improve hypertension, diabetes, and cardiovascular disease management and control.
		Improve access to mental health and substance use disorder care.
	Identify and implement initiatives to close care gaps and address health disparities for underserved communities.	Advance interventions which address social determinants of health.
		Identify enrollees who are experiencing homelessness and provide care coordination and case management.
		Identify potential enrollees who are transitioning from incarceration and provide support through the eligibility process and their reentry into the community.

Aim	Goal	Objective
Reduce the Per Capita Cost of Health Care 	Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions.	Reduce the number of emergency department visits for substance use disorders.
		Increase the percentage of adults who initiate and continue treatment after diagnosis of alcohol or other drug abuse/dependence.
		Improve maternal health and reduce the pre-term birth rate in Medicaid beneficiaries.
	Pay for value and incentive innovation.	Incorporate into Heritage Health contracts incentives for improving health outcomes.

Each of the 25 objectives is tied to a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the quality strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, these interventions are tied to a series of performance measures. MLTC will be monitoring the performance measures in order to evaluate the effectiveness of the quality strategy.

HSAG made recommendations in the CY 2023–2024 EQR technical report for MLTC based on the conclusions drawn from activities conducted. Table 2-12 is summary of the follow-up actions that MLTC completed in response to HSAG's recommendations. The information included within the "MLTC Action" column of this table was provided by MLTC.

Table 2-12—HSAG Recommendations with MLTC Actions

HSAG CY 2023–2024 Recommendations	Associated Quality Strategy Goal	MLTC Action
MLTC can support the MCOs in improving performance measure scores that are currently below the NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark by encouraging the MCOs to identify barriers related to these performance measures and to implement interventions targeting these performance measures.	 Promote wellness and prevention.	MLTC conducts monthly meetings with each MCO, and one of the standing agenda items is the discussion of barriers to care and performance measures. MLTC will continue these brainstorming sessions to achieve continuous improvement by modifying the design and implementation of interventions.
MLTC can support statewide access to dental specialists and access to behavioral health outpatient assessment and treatment providers through expanding telehealth services and working to identify root causes for the lack of access to dental specialists in specific regions.	 Expand access to high-quality services to meet the needs of diverse clients.	MLTC participates in monthly meetings with the Nebraska Dental Association, American Dental Association, MCOs, dental schools, Federally Qualified Health Centers, and other stakeholders to explore barriers to care, access, and adequacy of the dental network. These ongoing discussions include possible interventions and goal

HSAG CY 2023–2024 Recommendations	Associated Quality Strategy Goal	MLTC Action
		setting to measure success. MLTC also encouraged the MCOs to offer competitive rates to providers in rural and frontier areas of the State to fill in access gaps. Behavioral health outpatient assessment and treatment access through telehealth was expanded during the public health emergency (PHE). Those privileges were maintained after the PHE. Access was expanded in 2024 to include substance use assessment.

Recommendations for the Nebraska DHHS Quality Strategy for Heritage Health Program

HSAG's EQR results and guidance on actions assist MLTC in evaluating the MCOs' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist MLTC and the MCOs in achieving and exceeding goals. In addition to providing each MCO with specific guidance, HSAG offers MLTC the following recommendations, which should positively impact the quality, timeliness, and accessibility of services provided to Medicaid members. HSAG's specific recommendations are included in Table 2-13.

Table 2-13—Recommendations for Heritage Health Program

Program Recommendations		
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**
Quality	HSAG recommends that DHHS work with MCOs to determine whether children and adolescent members receive a weight assessment and education on healthy habits during visits with a PCP. HSAG also recommends that DHHS determine if the MCOs are following up annually with sexually active members through various modes of communication such as emails, phone calls, or text messages to ensure members return for yearly screening.	Promote wellness and prevention.
Quality	HSAG recommends that DHHS conduct a root cause analysis to ensure the MCOs are aware of appropriate treatments for URI. Additionally, HSAG recommends that MCO providers evaluate their noncompliant claims to confirm there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	Timely decision making. Promote wellness and prevention.
Quality, Timeliness, and Access	HSAG recommends that DHHS work with the MCOs to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs.	Improve chronic disease management and control.

Program Recommendations		
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**
Quality and Access	HSAG recommends that DHHS work with the MCOs to implement targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. HSAG also recommends that the MCOs identify best practices for ensuring children receive timely and medically appropriate well-care services.	Expand access to high-quality services to meet the needs of diverse clients. Promote wellness and prevention.
Quality, Timeliness, and Access	HSAG recommends that DHHS work with each MCO to review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes.	Promote wellness and prevention.
Quality, Timeliness, and Access	HSAG recommends that DHHS revise MCO contract requirements to remedy operational and reporting practices and processes for the informal reconsideration and peer-to-peer processes. The MCOs' review of prior-authorization denials with the enrollees' providers after the MCOs send enrollees notices of adverse benefit determinations is consistent with CMS' definition of an appeal. DHHS should work with the MCOs to ensure appropriate initial prior-authorization decisions, designate informal reconsiderations and peer-to-peer discussions as appeals, confirm enrollees' consent for providers to appeal on their behalf, validate the content within the notices of adverse benefit determinations is consistent with the requirements, and accurately report appeals information to DHHS.	Timely decision making.
Access	HSAG recommends that DHHS work with the MCOs on the provider categories for which the MCOs did not meet the time/distance standard. Additionally, HSAG recommends that the MCOs assess whether this is due to lack of providers available for contracting in the area, the lack of providers willing to contract with the MCOs, the inability to identify the providers in the data, or for other reasons.	Build transparent and trusting stakeholder relationships.
Access	HSAG recommends that DHHS collaborate with the MCOs to continue exploring best practices and incentive programs that other organizations may have used to increase member access to care. In addition, the MCOs should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed.	Expand access to high-quality services to meet the needs of diverse clients. Pay for value and incentive innovation.
Quality, Timeliness, and Access	To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), DHHS should update the contracts with its MCOs as follows within the required effective dates for each specific requirement: • Require the MCOs to respond to prior-authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services.	Timely decision making. Increase member satisfaction.

Program Recommendations		
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**
	• Require the MCOs to publicly report prior-authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MCO performed over time for approvals and denials. This requirement is to ensure transparency and accountability in the healthcare system and allow for the efficiency of prior-authorization practices of each MCO, and enables the MCOs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining necessary checks for quality and appropriateness of care.	Increase provider satisfaction.
Quality, Timeliness, and Access	To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F), DHHS should implement the following within the required effective dates for each specific requirement: • Review the maximum appointment wait times standards (e.g., 10 business days for outpatient mental health and SUD appointments) and update its contracts with its MCOs, as applicable. • Contract with an independent vendor to perform secret shopper surveys of MCO compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to DHHS within three days of discovery. Results from the secret shopper survey will provide assurances to DHHS that the MCOs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members. • Conduct an annual member experience survey, by DHHS or its contracted vendor, to ensure consistency in administration within its managed care program. Because the member experience survey results will provide direct and candid input from members, DHHS and its MCOs can use the results to determine if their networks offer an appropriate range of services and access as well as if they provide a sufficient number, mix, and geographic distribution of providers to meet their members' needs. DHHS will be required to post the results of the survey on its website annually in accordance with 42 CFR §438.10(c)(3).	Expand access to high-quality services to meet the needs of diverse clients. Increase member satisfaction.

3. Methodology

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving MCO processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each MCO's compliance with requirements set forth in 42 CFR §438.330(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[14]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling

[14] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations. The MCOs used a standardized PIP submission form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP submission form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG evaluated each required step on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS Protocol 1,[15] HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

[15] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed CMS Protocol 1[16] requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to health care quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 3-1.

Table 3-1—Assignment of PIPs to the Quality, Timeliness, and Access Domains

MCO	Performance Improvement Project	Quality	Timeliness	Access
NTC	*Plan All-Cause Readmissions*	✓		
NTC	*Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*	✓	✓	
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	✓		
UHCCP	*Improving the Member Experience with the Health Plan's Member Services*	✓		

[16] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

Validation of Performance Measures

Objectives

In accordance with 42 CFR §438.330(c), states must require MCOs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the performance measure validation (PMV) process were to:

- Evaluate the accuracy of performance measure data collected by the MCO.
- Determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

HEDIS Reporting

DHHS required MCOs operating in Nebraska during calendar year 2023 to undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA LO. CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[17] identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the FAR for the two MCOs that underwent a HEDIS Compliance Audit this year for the calendar year 2023 measurement period (i.e., MY 2023)—**NTC** and **UHCCP**—and aggregated several sources of HEDIS-related data to confirm that the MCOs met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately. HSAG received the MY 2023 FARs and Interactive Data Submission System (IDSS) workbooks from **NTC** and **UHCCP** by August 2, 2024, and completed the review of these materials by August 23, 2024. HSAG did not request a FAR from **Molina** because the MCO was not operating in Nebraska during calendar year 2023.

[17] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

The following processes/activities constitute the standard practice for HEDIS Compliance Audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[18]

- Teleconference calls with the MCO's personnel and vendor representatives, as necessary.
- Detailed review of the MCO's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the MCO's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate MRR data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the determinations of the MCO's MRR contractor for the same records.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS MY 2023 rates as presented within the NCQA-published IDSS completed by the MCO and/or its contractor.

NTC and **UHCCP** were responsible for obtaining and submitting their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the MCO's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the MCOs, it did review the audit reports produced by the other LOs. Through review of each MCO's FAR, HSAG determined whether all LOs followed NCQA's methodology in conducting their HEDIS Compliance Audits.

Core Set Reporting

In addition to HEDIS measures, DHHS required MCOs operating in Nebraska during calendar year 2023 to report on selected measures from the Centers for Medicare & Medicaid Services (CMS) Adult

[18] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

and Child Core Sets using a DHHS-supplied reporting template. Data reported by the MCOs on the CMS Adult and Child Core Set measures were not required to have undergone independent validation, except for those measures denoted with an NCQA measure steward; however, some MCOs opted to work with a vendor to audit their Core Set measure rates. HSAG requested copies of the reporting template from the two MCOs that reported Core Set measure data to DHHS for MY 2023 and received completed templates by September 30, 2024. In this report, HSAG presents only MCO-reported Core Set measure rates that have undergone independent validation.

Description of Data Obtained

HEDIS Reporting

As identified in the HEDIS Compliance Audit methodology, the following key types of data were obtained and reviewed as part of the PMV activity:

1. **FARs:** The FARs, produced by the MCOs' LOs, provided information on the MCOs' compliance to IS standards and audit findings for each measure required to be reported.
2. **Rate Files for the Current Year:** Final rates provided by the MCOs in IDSS format were reviewed to determine trending patterns and rate reasonability.

Core Set Reporting

The following types of data were obtained as part of this PMV activity:

1. **Reporting Template for the Current Year**: MCOs populated a DHHS-supplied template to report MY 2023 Core Set measure data to DHHS. HSAG obtained a copy of this template from each reporting MCO.
2. **Validation Report**: In addition to its reporting template, **NTC** provided a document discussing the validation of each required Adult and Child Core Set measure and confirming that **NTC**'s MY 2023 rates are reportable. **UHCCP** did not provide a validation report.

The MCOs' independently validated rates on Core Set measures are presented in this report. Table 3-2 lists the Adult and Child Core Set measures DHHS required the MCOs to report for MY 2023.

Table 3-2—CMS Core Set Measures Required by DHHS for MY 2023

Core Set Measures
CMS Adult Core Set Measures
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
Concurrent Use of Opioids and Benzodiazepines (COB-AD)
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

Core Set Measures
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) [Rate 1]
CMS Child Core Set Measures
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
Developmental Screening in the First Three Years of Life (DEV-CH)

How Data Were Aggregated and Analyzed

HEDIS Reporting

HSAG collected IDSS files and FARs for MY 2023 from **NTC** and **UHCCP**. HSAG reviewed the documentation to evaluate the accuracy of the data and to identify any issues of noncompliance or problematic performance measures. HSAG then provided recommendations and conclusions to DHHS based on measure rates falling at or above the 50th or below the 25th performance measure percentiles based on NCQA's Health Maintenance Organization (HMO) Quality Compass HEDIS MY 2023 percentile benchmarks. HSAG did not collect IDSS files or a FAR from **Molina** because the MCO was not operating in Nebraska during calendar year 2023.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the PMV activity conducted.

Core Set Reporting

HSAG collected the Core Set reporting templates for MY 2023 from **NTC** and **UHCCP**. In addition to the MY 2023 Core Set reporting template, **NTC** provided HSAG with documentation confirming that its MY 2023 rates on the DHHS-selected Adult and Child Core Set measures were independently validated. HSAG presented **NTC**'s independently validated Core Set measure rates in this report and did not present **UHCCP**'s unvalidated Core Set measure rates.

How Conclusions Were Drawn

Information Systems Standards Review

The MCOs must be able to demonstrate compliance with IS standards. MCOs' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG

reviewed and evaluated all data sources to determine MCO compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[19] The IS standards are listed as follows:

- IS R—Data Management and Reporting (formerly IS 6.0 and 7.0)
- IS C—Clinical and Care Delivery Data (formerly IS 5.0)
- IS M—Medical Record Review Processes (formerly IS 4.0)
- IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)

In the measure results tables presented in *Section 2* and the *appendices*, HEDIS MY 2023 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA LO according to NCQA standards. With regard to the final measure rates for HEDIS MY 2023, a measure result of *Small Denominator* (*NA*) indicates that the MCO followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the MCO chose not to report the measure.

Performance Measure Results

HEDIS Reporting

The MCOs' measure results were evaluated based on statistical comparisons.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the specific size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for MCO 1
R_1 = the rate for MCO 1
P_2 = the eligible population for MCO 2
R_2 = the rate for MCO 2

Measure results for HEDIS MY 2023 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2023.

[19] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington, D.C.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-3. The measures marked *NA* are related to utilization of services.

Table 3-3—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measures	Quality	Timeliness	Access
Effectiveness of Care: Prevention and Screening			
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	✓		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	✓		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	✓		
CIS: Childhood Immunization Status—Combination 3	✓		✓
CIS: Childhood Immunization Status—Combination 7	✓		✓
CIS: Childhood Immunization Status—Combination 10	✓		✓
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	✓		
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	✓		
LSC: Lead Screening in Children	✓	✓	
CCS: Cervical Cancer Screening	✓		
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	✓		
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	✓		
CHL: Chlamydia Screening in Women—Total	✓		
COL: Colorectal Cancer Screening—Ages 46 to 50 Years	✓		
COL: Colorectal Cancer Screening—Ages 51 to 75 Years	✓		
COL: Colorectal Cancer Screening—Total	✓		
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17 Years	✓		
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64 Years	✓		
CWP: Appropriate Testing for Pharyngitis—Ages 65 Years and Older	✓		
CWP: Appropriate Testing for Pharyngitis—Total	✓		
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	✓		✓

Performance Measures	Quality	Timeliness	Access
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	✓	✓	
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	✓	✓	
AMR: Asthma Medication Ratio—Ages 5 to 11 Years	✓		
AMR: Asthma Medication Ratio—Ages 12 to 18 Years	✓		
AMR: Asthma Medication Ratio—Ages 19 to 50 Years	✓		
AMR: Asthma Medication Ratio—Ages 51 to 64 Years	✓		
AMR: Asthma Medication Ratio—Total	✓		
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure	✓	✓	
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	
Effectiveness of Care: Diabetes			
HBD: Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)	✓		
HBD: Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)	✓		
BPD: Blood Pressure Control for Patients With Diabetes—Blood Pressure < 140/90 mm Hg	✓		
EED: Eye Exam for Patients With Diabetes	✓		
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	✓		
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	✓		
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	✓	✓	✓
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17 Years	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17 Years	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64 Years	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64 Years	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 Years and Older	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	✓	✓	✓
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	✓	✓	✓
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	✓	✓	✓
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—Total	✓	✓	✓
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	✓	✓	✓
FUA: Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	✓	✓	✓
FUA: Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	✓	✓	✓
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	✓		
SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓		
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—Ages 1 to 11 Years	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—Ages 12 to 17 Years	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—Total	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol—Ages 1 to 11 Years	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol—Ages 12 to 17 Years	✓		

Performance Measures	Quality	Timeliness	Access
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol—Total	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol—Ages 1 to 11 Years	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol—Ages 12 to 17 Years	✓		
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol—Total	✓		
Effectiveness of Care: Overuse/Appropriateness			
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older	✓		
URI: Appropriate Treatment for Upper Respiratory Infection—Total	✓		
LBP: Use of Imaging Studies for Low Back Pain—Total	✓		
HDO: Use of Opioids at High Dosage—Average Morphine Milligram Equivalent Dose [MME] ≥ 90	✓		
AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years	✓		
AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years	✓		
AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older	✓		
AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	✓		
Access/Availability of Care			
IET: Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Ages 13 to 17 Years	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—Ages 13 to 17 Years	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Ages 18 to 64 Years	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
IET: Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—Ages 18 to 64 Years	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Ages 65 Years and Older	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—Ages 65 Years and Older	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—Total	✓	✓	✓
IET: Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—Total	✓	✓	✓
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	✓	✓	✓
PPC: Prenatal and Postpartum Care—Postpartum Care	✓	✓	✓
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Ages 1 to 11 Years	✓		✓
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Ages 12 to 17 Years	✓		✓
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		✓
Utilization			
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓		✓
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	✓		✓
AMB: Ambulatory Care (Per 1,000 Member Years)—Emergency Department Visits—Total	NA	NA	NA
AMB: Ambulatory Care (Per 1,000 Member Years)—Outpatient Visits, Including Telehealth—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Years—Total Inpatient—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Years—Maternity—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total	NA	NA	NA

Performance Measures	Quality	Timeliness	Access
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Years—Surgery—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Years—Medicine—Total	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total	NA	NA	NA
WCV: Child and Adolescent Well-Care Visits—Ages 3 to 11 Years	✓		✓
WCV: Child and Adolescent Well-Care Visits—Ages 12 to 17 Years	✓		✓
WCV: Child and Adolescent Well-Care Visits—Ages 18 to 21 Years	✓		✓
WCV: Child and Adolescent Well-Care Visits—Total	✓		✓
Risk Adjusted Utilization			
PCR: Plan All-Cause Readmissions—Observed Readmissions—Ages 18 to 64 Years	✓		
PCR: Plan All-Cause Readmissions—Expected Readmissions—Ages 18 to 64 Years	✓		
PCR: Plan All-Cause Readmissions—O/E Ratio—Ages 18 to 64 Years	✓		
Measures Collected Using Electronic Clinical Data Systems			
BCS-E: Breast Cancer Screening	✓		
PND-E: Prenatal Depression Screening and Follow-Up—Depression Screening	✓	✓	
PND-E: Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen	✓	✓	
PDS-E: Postpartum Depression Screening and Follow-Up—Depression Screening	✓	✓	
PDS-E: Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen	✓	✓	

Core Set Reporting

Additionally, the assignment to domains of care is depicted in Table 3-4 for the Core Set measures.

Table 3-4—Assignment of Core Set Measures to the Quality, Timeliness, and Access Domains

Core Set Measures	Quality	Timeliness	Access
CMS Adult Core Set Measures			
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)	✓	✓	✓

Core Set Measures	Quality	Timeliness	Access
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	✓	✓	
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	✓		
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	✓		
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) [Rate 1]	✓		✓
CMS Child Core Set Measures			
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)	✓	✓	✓
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)	✓	✓	✓
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	✓	✓	
Developmental Screening in the First Three Years of Life (DEV-CH)	✓	✓	✓

Assessment of Compliance With Medicaid Managed Care Regulations

Table 3-5 delineates the compliance review activities as well as the standards that were reviewed during the current three-year compliance review cycle. CAPs from findings during the CY 2023–2024 compliance reviews were evaluated and resolved in 2024.

Table 3-5—Summary of Compliance Standards and Associated Regulations

	Year One (CY 2022–2023)	Year Two (CY 2023–2024)	Year Three (CY 2024–2025)
Standard	**Review of Standards**		
Standard I—Enrollment and Disenrollment	✓		
Standard II—Member Rights and Confidentiality		✓	✓
Standard III—Member Information		✓	✓
Standard IV—Emergency and Poststabilization Services	✓		✓
Standard V—Adequate Capacity and Availability of Services		✓	
Standard VI—Coordination and Continuity of Care		✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection and Program Integrity	✓		
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		✓
Standard XI—Health Information Systems	✓		
Standard XII—Quality Assessment and Performance Improvement	✓		

	Year One (CY 2022–2023)	Year Two (CY 2023–2024)	Year Three (CY 2024–2025)
Standard	**Review of Standards**		
Standard XIII—Grievance and Appeal System		✓	✓

HSAG divided the federal regulations into 13 standards consisting of related regulations and contract requirements. Table 3-6 describes the standards and associated regulations and requirements reviewed for each standard.

Table 3-6—Summary of Compliance Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection and Program Integrity	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems*	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal System	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	* Requirement §438.242: Validation of IS standards for each MCO was conducted under the PMV activity.	

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to DHHS and the MCOs regarding:

- The MCOs' compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCOs into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care furnished by the MCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the MCOs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[20] Table 3-7 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 3-7—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DHHS contract requirements: • HSAG and DHHS collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted monitoring tools, record review tools, report templates, and agendas, and sent review dates to DHHS for review and approval. • HSAG forwarded all the materials to the MCOs. • HSAG conducted training for all reviewers to ensure consistency in scoring across the MCOs. • HSAG scheduled the virtual reviews and distributed the agendas to the MCOs to facilitate preparation for the reviews.

[20] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

For this protocol activity,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO training webinar to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations. • HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • No less than 60 days prior to the scheduled date of the review, HSAG notified the MCO in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. Forty-five days prior to the review, the MCO provided data files from which HSAG chose sample grievance, appeal, and denial cases to be reviewed. HSAG provided the final samples to the MCOs via HSAG's secure access file exchange (SAFE) site. No less than 30 days prior to the scheduled review, the MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCO's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCO Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics, for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2024–2025 DHHS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • HSAG analyzed the findings and calculated final scores based on DHHS-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.

For this protocol activity,	HSAG completed the following activities:
Activity 5:	**Report Results to DHHS**
	• HSAG populated and submitted the draft reports to DHHS and the MCOs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCO and DHHS.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Interviews with key MCO staff members conducted virtually

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key MCO personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to DHHS and to each MCO for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of care furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCOs. Table 3-8 depicts assignment of the standards to the domains of care.

Table 3-8—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard X—Practice Guidelines	✓		
Standard XIII—Grievance and Appeal System	✓	✓	✓

Validation of Network Adequacy

Objectives

In accordance with 42 CFR §438.68, states must set quantitative network adequacy standards for MCOs to ensure they are maintaining provider networks sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across a continuum of services. With the publication of the most recent EQR Protocols in February 2023, validation of the MCOs' compliance with these network adequacy standards is a mandatory EQR activity.

The primary objectives for the NAV were to:

1. Collaborate with DHHS to identify and define its network adequacy indicators for validation, identify and define the provider types that are subject to standards, review the MCOs' information systems and processes for collecting network adequacy data, and assess the reliability and validity of MCO network adequacy data, methods, and results. The indicators validated are listed in *Appendix E.*
2. Perform an independent time and distance analysis calculating the percentage of members with access to providers within time and distance standards.
3. Synthesize the information collected and calculate validation ratings for all indicators, summarizing validation findings.
4. Perform additional analyses to provide DHHS with further insight regarding network adequacy.

Technical Methods of Data Collection

ISCA

HSAG collaborated with DHHS to develop an ISCAT consistent with Worksheet A.1 of CMS Protocol 4.[21] The ISCAT was designed to collect information and evaluate the capabilities of each MCO's information systems infrastructure to monitor network standards in accordance with the requirements of the protocol. The document request packet, which included the ISCAT, requested documentation regarding each MCO's data practices, methodologies, policies and procedures; and provider mapping documents to support HSAG's ability to assess the MCOs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. The

[21] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

HSAG EQRO team members, MCO staff, and all applicable vendors participated together to identify all data sources informing calculation and reporting at the network adequacy indicator level.

The DRP included an outline of the activities to be conducted during the validation process, a timetable for completion, and instructions for submission. HSAG hosted an all-plan webinar focused on providing technical assistance to the health plans to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review.

Geographic Access Methodology and Network Capacity

HSAG requested Medicaid member files from DHHS and from each MCO. HSAG submitted a detailed member data requirements document to DHHS and the MCOs, and allowed for a technical assistance call to review the data request in detail and clarify any questions regarding the data request. HSAG requested data for members actively enrolled in an MCO as of June 1, 2024, including these key data elements: members' street address, city, state, ZIP Code, date of birth, dates of enrollment, and MCO affiliation.

HSAG requested Medicaid provider files from DHHS reflecting all providers enrolled in the State's Medicaid program. From the MCOs, HSAG requested provider files reflecting all active providers serving its Medicaid members. HSAG requested the following key data elements: provider name, NPI, address, provider category used for reporting in the quarterly GeoAccess reports, provider type, specialty, and taxonomy codes.

HSAG requested quarterly GeoAccess reports for the periods from January 1, 2024, through March 31, 2024, and April 1, 2024, through June 30, 2024, from both the MCOs and DHHS.

Description of Data Obtained

The following key types of data were obtained and reviewed as part of the CY 2024–2025 NAV activity:

ISCA

- ISCATs and requested documentation submitted by each MCO
- Virtual review sessions attend by the EQRO team, MCO staff, and any applicable vendors

Geographic Access and Network Capacity Analyses

- Medicaid member data files from DHHS for members enrolled in an MCO as of June 1, 2024
- Provider data files from the MCOs showing providers contracted in their network as of June 1, 2024
- Quarterly network adequacy reports submitted by the MCOs to DHHS for 2024

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual review, and all additional documents submitted by the MCOs.

ISCA

HSAG completed a desk review of the submitted ISCAT and supporting documents to understand the processes for maintaining and updating member, provider, and other data systems used in network adequacy reporting to assess the ability of the health plan's information systems to collect and report accurate data required for the calculation of network adequacy indicators. This involved understanding selected characteristics of the health plan's information technology (IT) system architecture, file structure, information flow, data processing procedures, and how these ensure the completeness and accuracy of data and indicator calculation necessary to support compliance with network adequacy standards. HSAG thoroughly reviewed all documentation, noting issues, concerns, and items that need clarification.

HSAG's desk review continued by conducting virtual interviews with MCO staff members, which included health plan network-related information systems demonstrations and discussion of data management processes described in the ISCAT submission.

HSAG indicated whether each MCO provides results for all State network adequacy indicators in its network adequacy monitoring activities. HSAG then provided a validation rating for each indicator, noting any indicators that could not be validated due to missing or incomplete data or for other reasons, and adding appropriate comments to explain challenges and opportunities for improvement. HSAG submitted findings and identified opportunities for improvement to DHHS and the MCOs. HSAG summarized its NAV findings in an aggregate report to DHHS.

HSAG assessed the MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCO and State network adequacy monitoring. HSAG likewise assessed whether the results were valid, accurate, reasonable, and reliable, and whether the MCO's interpretation of the results was accurate.

Geographic Access and Network Capacity Analyses

HSAG conducted an independent evaluation of the geographic distribution of providers relative to each MCO's members using software from Quest Analytics to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to two providers for all provider categories identified in the analysis. These results were compared to the GeoAccess results reported by the MCOs to assess whether MCO results were valid, accurate, reliable, reproducible, consistent, and accurately interpreted by the MCOs.

HSAG used a state-approved NAV aggregate report template to document the NAV findings and submit the draft and final NAV aggregate report according to the state-approved timeline. The geographic access standards and provider categories are provided in *Appendix E*. For each MCO, HSAG calculated

the percentage of members with required access according to the time and distance standards, and evaluated whether the required percentage of members met the applicable time or distance standard. HSAG used Quest Analytics to calculate the travel time or distance between the addresses of specific members for all provider categories identified in the analysis. A higher percentage of members meeting access standards indicates better geographic distribution of an MCO's providers in relation to its Medicaid members.

HSAG visually compared its time and distance results to MCO-submitted results included in the quarterly GeoAccess reports for general consistency and reasonability.

HSAG calculated the provider-to-member ratio for each provider category and MCO included in the analyses. The provider ratio measures the number of providers by provider category (e.g., PCPs, high-volume specialists, dentists, pharmacies, and hospitals) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available[22] to render services to individuals. Provider counts for this analysis were based on unique providers and not provider service locations. DHHS has not set standards for provider ratios, and the results of this analysis were informational only and were not intended as an evaluation of MCOs for meeting or failing to meet specific network capacity standards.

HSAG also continued the practice of prior years and used the same data to calculate the average travel distance (driving distance in miles) or travel time (in minutes) for providers with travel time standards to the nearest two providers. A shorter distance or travel time indicates greater access to providers since travel time and distance is a common barrier to members' ability to access care. This analysis was done for informational purposes only.

HSAG aggregated and analyzed all of the data obtained and the results of its independent analysis and used the CMS EQR Protocol 4 Worksheet 4.6[23] as a guide for a systematic assessment of the quality of MCO network adequacy data, methods, and results. The worksheet contains a list of questions designed to identify concerns with the MCOs' data systems, methodologies, and results. For example, questions include:

- Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP [managed care plan] to the EQRO?
- Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?
- In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?

[22] The provider ratio does not account for geographic access or key practice characteristics (e.g., panel capacity, acceptance of new patients, practice restrictions). Thus, the provider ratio provides a sense of the maximum potential availability of providers of a given type.

[23] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2025.

As directed by the protocol, HSAG completed the worksheet for each network adequacy indicator for each MCO. HSAG used the two-point scoring methodology designed by CMS, with each question scored as Yes or No according to the criteria identified below. HSAG used a designation of N/A if the requirement was not applicable to a health plan or indicator; N/A findings were not included in calculating the score for the indicator.

- *Yes* indicated that the health plan met expectations.
- *No* indicated that the health plan fully or partially failed to meet expectations.
- *Not Applicable (N/A)* indicated that the question did not apply to the health plan or the specific indicator.

How Conclusions Were Drawn

HSAG arrived at conclusions by summarizing the NAV findings for each MCO by indicator and preparing results modeled on CMS' Worksheet 4.7 that best speak to the overall results and findings, such as whether standards were addressed, HSAG's confidence rating, and comments on data quality or reliability.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. For each indicator, HSAG calculated a validation score equal to the number of "Yes" responses divided by the total number of "Yes" and "No" responses. Based on where the score fell within the ranges defined by CMS, the MCO was given a rating for the indicator of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The overall validation rating refers to HSAG's overall confidence that the MCO used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators.

The results of HSAG's independent geographic distribution analysis was used to inform its assessment of its confidence in the accuracy of the MCOs' reported results. HSAG used analysis of the network data obtained to draw conclusions about Nebraska Heritage Health member access to particular provider networks (e.g., primary, specialty, or dental health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

HSAG analyzed the quantitative results obtained from the NAV activity to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of care furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the activity conducted.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-9.

Table 3-9—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
Time and Distance Analysis—Percentage of members with access according to standards			✓
Protocol 4 Information Systems Capabilities Assessment—Validation of network adequacy assessment data, methods, and results			✓

Appendix A. Molina Healthcare of Nebraska

Validation of Performance Improvement Projects

Results

Molina's contract started January 1, 2024; therefore, final validation findings for **Molina**, including assessment of indicator results, interventions, strengths, opportunities for improvement, and recommendations, will be reported in next year's annual EQR technical report.

Validation Results and Confidence Ratings

Final validation results and confidence ratings will be reported in next year's annual EQR technical report.

Performance Indicator Results

Molina will report final indicator results in CY 2025–2026. HSAG will validate the performance indicator results in CY 2025–2026, and the final performance indicator results for each PIP topic will be included in next year's annual EQR technical report.

Interventions

Molina will report final quality improvement activities and interventions in CY 2025–2026. A summary of **Molina**'s interventions for each PIP topic will be included in next year's annual EQR technical report.

Strengths

HSAG will report strengths for **Molina**'s PIPs in next year's annual EQR technical report, when HSAG has completed the first annual validation cycle for **Molina**'s PIPs in CY 2025–2026.

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG will report opportunities for improvement and recommendations for **Molina**'s PIPs in next year's annual EQR technical report, when HSAG has completed the first annual validation cycle for **Molina**'s PIPs in CY 2025–2026.

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, or PAHP, has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. However, **Molina** was a new MCO to Nebraska as of January 1, 2024; therefore, **Molina** did not have prior year recommendations from the EQRO.

Validation of Performance Measures

Results for Information Systems Standards Review

Molina was a new MCO to Nebraska as of January 1, 2024; therefore, **Molina** did not have a MY 2023 FAR to submit for CY 2024–2025 reports. As such, HSAG's assessment of **Molina**'s performance on each HEDIS IS standard is not reflected in this CY 2024–2025 EQR technical report. However, results for **Molina** will be included in next year's annual EQR technical report.

Results for Performance Measures

As a new MCO to Nebraska as of January 1, 2024, **Molina** did not have MY 2023 data to submit for the CY 2024–2025 report. As such, HSAG did not conduct validation of performance measures for **Molina** for CY 2024–2025. Therefore, final validation findings are not reflected in the CY 2024–2025 technical report. However, results for **Molina** will be included in next year's annual EQR technical report.

Strengths

HSAG will report strengths for **Molina**'s data and FAR in next year's annual EQR technical report, when HSAG has completed the first annual validation for **Molina** in CY 2025–2026.

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG will report opportunities for improvement and recommendations for **Molina**'s data and FAR in next year's annual EQR technical report, when HSAG has completed the first annual validation for **Molina** in CY 2025–2026.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, or PAHP, has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. However, **Molina** was a new MCO to Nebraska as of January 1, 2024; therefore, **Molina** did not have prior year recommendations from the EQRO.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table A-1—Compliance With Regulations—Trended Performance for Molina

Standard and Applicable Review Years*	Year One (CY 2022–2023)**	Year Two (CY 2023–2024)**	Year Three (CY 2024–2025)**
Standard Number and Title	**Molina Results**		
Standard I—Enrollment and Disenrollment			
Standard II—Member Rights and Confidentiality			66.7%
Standard III—Member Information			86.4%
Standard IV—Emergency and Poststabilization Services			100%
Standard V—Adequate Capacity and Availability of Services			
Standard VI—Coordination and Continuity of Care			100%
Standard VII—Coverage and Authorization of Services			84.2%
Standard VIII—Provider Selection and Program Integrity			
Standard IX—Subcontractual Relationships and Delegation			
Standard X—Practice Guidelines			100%
Standard XI—Health Information Systems			
Standard XII—Quality Assessment and Performance Improvement			
Standard XIII—Grievance and Appeal System			92.0%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.

Grey shading indicates standards for which no comparison results are available. **Molina's contract started January 1, 2024; therefore, **Molina** was not reviewed during Year One and Two.

Strengths

Molina submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Three out of seven standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

Molina achieved full compliance for the Emergency and Poststabilization Services standard, demonstrating the MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. **[Timeliness and Access]**

Molina achieved full compliance for the Coordination and Continuity of Care standard, demonstrating the MCO had adequate processes in place for its care management program. **[Quality, Timeliness, and Access]**

Molina achieved full compliance for the Practice Guidelines standard, demonstrating the MCO had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. **[Quality]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

Molina should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

Molina received a score of 66.7 percent for the Member Rights and Confidentiality standard. As a result, HSAG recommended that **Molina** update the list of member rights in the member handbook to include all rights listed in the Member Rights and Responsibility Policy. Additionally, the MCO must update this member right in its applicable policies and member handbook to state, "receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand." Furthermore, the MCO must maintain written policies and procedures and provide written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCO. **[Access]**

Molina received a score of 86.4 percent for the Member Information standard. As a result, the MCO must meet all requirements when providing information electronically, as follows

- The format is readily accessible. (Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines.)
- The information is placed in a website location that is prominent and readily accessible.
- The information can be electronically retained and printed.
- The information complies with content and language requirements.
- The member is informed that the information is available in paper form without charge upon request and is to be provided within five business days.

Additionally, for the Member Information standard, the MCO must include in the member handbook the following information regarding the grievance and State fair hearing procedures:

- For grievances:
  - The availability of assistance in the filing processes.
- For State fair hearings:
  - The availability of assistance to request a State fair hearing.

Also, the member handbook did not include information to inform members that they may request reports of transactions between the MCO and parties in interest (as defined in 1318[h] of the Public Health Service Act) provided to the State. The MCO must include a statement in the member handbook that informs members of the information available to members, upon request, which includes:

- The structure and operation of the MCO. The MCO's physician incentive plans.
- The MCO's service utilization policies.
- How to report alleged marketing violations.
- Reports of transactions between the MCO and parties in interest (as defined in 1318[h] of the Public Health Service Act) provided to the State. **[Access]**

For the Emergency and Poststabilization Services standard, HSAG recommended that **Molina** add specific language to a policy and procedure to further clarify that the MCO limits charges to members for poststabilization care services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through an in-network provider. **[Timeliness and Access]**

Molina received a score of 84.2 percent for the Coverage and Authorization of Services standard. As a result, HSAG recommended that the HCS 325.01 Service Authorization policy be revised to align with its NE Addendum and include giving notice five calendar days before the date of action if probable member fraud has been verified. Also, the MCO must update its policies and procedures to include provisions for extending the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if the member or the provider requests an extension; or the MCO justifies (to the State upon request) a need for additional information and how the extension is in the member's interest. Additionally, **Molina** must mail the NABD within the following time frames: for standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization; for expedited service authorization decisions, within 72 hours of the request for authorization; for service authorization decisions not reached within the 14-calendar-day or 72-hour time frames, on the date these time frames expire. Furthermore, **Molina**'s NABD must be in writing and meet the language and format requirements of 42 CFR §438.10(c). **[Timeliness and Access]**

Molina received a score of 92.0 percent for the Grievance and Appeal System. As a result, **Molina** must ensure acknowledge receipt of each appeal in writing within 10 calendar days of receipt of the appeal and use the correct letter template. Additionally, **Molina**'s appeal resolution notices must be in writing and meet the language and format requirements of 42 CFR §438.10. **[Quality, Timeliness, and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, or PAHP, has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. However, **Molina** was a new MCO to Nebraska as of January 1, 2024; therefore, **Molina** did not have prior year recommendations from the EQRO.

Validation of Network Adequacy

Results

Findings on the Information Systems Capabilities Assessment

HSAG completed an ISCA for **Molina** and presented the ISCA findings and assessment of any concerns related to data sources used in the NAV to DHHS and **Molina**.

- HSAG evaluated the information systems data processing procedures and personnel that **Molina** had in place to support network adequacy indicator reporting. HSAG identified no concerns with **Molina**'s information systems data processing procedures and personnel.
- HSAG evaluated the information systems and processes used by **Molina** to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG identified no concerns with **Molina**'s enrollment data capture, data processing, data integration, data storage, or data reporting.
- HSAG did not identify any delegated entity network adequacy data-related items for **Molina** requiring corrective action during the review period. HSAG identified no concerns with **Molina**'s network adequacy indicator results or reporting processes.

Overall, HSAG determined that **Molina**'s data collection procedures, network adequacy methods, and network adequacy results were acceptable.

Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **Molina** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table A-2 summarizes HSAG's validation ratings for **Molina** by indicator type, with **Molina** receiving *High Confidence* for all access and availability and time and distance indicators.

Table A-2—Summary of Molina's Validation Findings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time and Distance (n = 43)	100%	0%	0%	0%
Access and Availability (n = 17)	100%	0%	0%	0%

N = the number of indicators of that type.

Time and Distance Standards

DHHS has set geographic access standards that require a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier). As mentioned previously, the exception is for access to hospitals, optometrists, and ophthalmologists, for which the standard is defined in terms of a maximum travel time (30 minutes) from the member's residence.

Table A-3 displays the percentage of **Molina**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table A-3–Percentage of Molina Members with Required Access to Care by Provider Category and Urbanicity

Provider Category	Percentage of Members With Required Access*
PCP, Urban	>99.9%
PCP, Rural	>99.9%
PCP, Frontier	100.0%
High-Volume Specialists**	
Cardiology	>99.9%
Neurology	100.0%
OB/GYN	>99.9%
Oncology-Hematology	99.8%
Orthopedics	100.0%
Pharmacy, Urban***	96.6%
Pharmacy, Rural***	93.8%
Pharmacy, Frontier***	98.2%
All Behavioral Health Inpatient and Residential Service Providers, Urban	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Rural	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Frontier	100.0%

Provider Category	Percentage of Members With Required Access*
All Behavioral Health Outpatient Assessment and Treatment Providers, Urban	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Rural	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	98.6%
Hospitals	97.5%
Optometry, Urban	95.3%
Optometry, Rural	85.9%
Optometry, Frontier	75.8%
Ophthalmology, Urban	97.5%
Ophthalmology, Rural	100.0%
Ophthalmology, Frontier	100.0%
Dental	
Dentist, Urban	100.0%
Dentist, Rural	100.0%
Dentist, Frontier	100.0%
Dental Specialists	
Oral Surgeon, Urban	92.3%
Oral Surgeon, Rural	70.1%
Oral Surgeon, Frontier	18.5%
Orthodontist, Urban	81.8%
Orthodontist, Rural	56.1%
Orthodontist, Frontier	84.6%
Periodontist, Urban	58.5%
Periodontist, Rural	18.7%
Periodontist, Frontier	0.0%
Pediadontist, Urban	99.4%
Pediadontist, Rural	84.7%
Pediadontist, Frontier	83.7%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity.
*The minimum access is required for 100 percent of members unless otherwise noted.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.
***For pharmacies, the standard must be met for 90 percent of members within urban counties, or 70 percent of members in rural and frontier counties.

Table A-4 displays the percentage of **Molina**'s members with the access to care required by contract standards for behavioral health provider categories by Behavioral Health Region.

Table A-4–Percentage of Molina Members with Required Access to Behavioral Health Services by Type of Service and Behavioral Health Region

Provider Category	Percentage of Members With Required Access*
All Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%
All Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	99.2%
Region 3	100.0%
Region 4	99.9%
Region 5	100.0%
Region 6	100.0%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.
*The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table A-5 identifies the counties where **Molina** did not meet the minimum geographic access standards in a specific urbanicity or Behavioral Health Region for each applicable provider category, including pediatric specialists for appropriate categories. Results are presented separately for the general and pediatric populations as applicable.

Table A-5– Counties Not Meeting Geographic Access Standard by Provider Category for Molina

Provider Category	Counties Not Meeting Standard*
PCP	
Urban	Lincoln
Rural	Cherry
High-Volume Specialists†**	
Cardiology	Cherry
OB/GYN	Dundy

Provider Category	Counties Not Meeting Standard*
Oncology-Hematology	Cherry
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Platte, Scotts Bluff
Rural	Cherry, Custer, Thayer
Frontier	Hooker, Thomas
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Grant, Hooker, Thomas
Region 2	Grant, Hooker, Lincoln, Thomas
Region 4	Cherry
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Buffalo, Burt, Cherry, Custer, Dakota, Dawes, Deuel, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Platte, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Optometry	
Urban	Adams, Buffalo, Gage, Lincoln, Madison, Platte
Rural	Box Butte, Cherry, Custer, Dawes, Fillmore, Jefferson, Keith, Nemaha, Nuckolls, Pawnee, Red Willow, Richardson, Thayer, Valley, Webster
Frontier	Chase, Dundy, Grant, Hitchcock, Hooker, McPherson, Sheridan
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln, Madison, Platte
Dental Specialists	
Oral Surgeon, Urban	Buffalo, Dawson, Gage, Lincoln, Madison, Scotts Bluff
Oral Surgeon, Rural	Antelope, Box Butte, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nemaha, Pawnee, Phelps, Pierce, Red Willow, Richardson, Thayer, Valley
Oral Surgeon, Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas
Orthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte

Provider Category	Counties Not Meeting Standard*
Orthodontist, Rural	Antelope, Boone, Butler, Cedar, Cherry, Clay, Colfax, Cuming, Custer, Dixon, Fillmore, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Orthodontist, Frontier	Boyd, Brown, Franklin, Garfield, Greeley, Keya Paha, Rock, Sherman, Wheeler
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Periodontist, Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Pediadontist, Urban	Dawson, Gage
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Furnas, Holt, Jefferson, Keith, Knox, Nemaha, Pawnee, Red Willow, Richardson, Thayer, Valley
Pediadontist, Frontier	Boyd, Brown, Dundy, Keya Paha, Rock, Sheridan

*Rows are only shown if at least one county did not meet the standard.
**The standard for this provider category does not differ by urbanicity.
†High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

Network Capacity Analysis

Table A-6 displays the statewide network capacity analysis results for **Molina** (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards. Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table A-6–Molina Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	6,390	1:18
High-Volume Specialists**		
Cardiology	336	1:327

Provider Category	Providers	Ratio*
Neurology	292	1:376
OB/GYN	402	1:92
Oncology-Hematology	185	1:593
Orthopedics	266	1:413
Pharmacy	481	1:228
All Behavioral Health Inpatient and Residential Service Providers	37	1:2,963
All Behavioral Health Outpatient Assessment and Treatment Providers	5,118	1:22
Hospitals	151	1:727
Optometry	107	1:1,025
Ophthalmology	105	1:1,045
Dental		
Dentist	386	1:285
Dental Specialists		
Oral Surgeon	23	1:4,767
Orthodontist	12	1:9,136
Periodontist	5	1:21,927
Pediadontist	59	1:940

Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
* In calculating the ratios, all covered members were considered, except in the case of OB/GYN providers, where the member population was limited to female members 15 years of age and older, and Pediadontists, where the member population was limited to members 18 years of age and younger.
** High-volume specialists are those identified by DHHS for purposes of the time and distance analysis.

As an additional point of information in evaluating adequacy of provider networks, the average time and distance to the nearest two providers were calculated across members enrolled in each MCO and for each provider category. Although this analysis included all provider categories, it did not consider urbanicity. Table A-7 displays the statewide average travel times (in minutes) and travel distances (in miles) to the first- and second-nearest providers for **Molina** members.

Table A-7—Molina Members' Average Time and Distance to the Nearest First and Second Provider

Provider Category	First Nearest*	Second Nearest*
	Time (Min.) Dist. (Mi.)	Time (Min.) Dist. (Mi.)
PCP	1.9 / 1.6	2.0 / 1.7
High-Volume Specialists**		

Provider Category	First Nearest*	Second Nearest*
	Time (Min.) Dist. (Mi.)	Time (Min.) Dist. (Mi.)
Cardiology	7.0 / 5.8	9.2 / 7.7
Neurology	9.3 / 7.8	11.5 / 9.8
OB/GYN	7.6 / 6.6	9.7 / 8.4
Oncology-Hematology	8.4 / 7.1	10.7 / 9.2
Orthopedics	6.8 / 5.6	8.0 / 6.8
Pharmacy	2.6 / 2.1	4.7 / 3.9
All Behavioral Health Inpatient and Residential Service Providers	19.1 / 16.6	26.0 / 22.1
All Behavioral Health Outpatient Assessment and Treatment Providers	1.9 / 1.6	2.6 / 2.3
Hospitals	5.9 / 4.7	10.0 / 8.4
Optometry	11.7 / 10.0	13.9 / 11.9
Ophthalmology	8.6 / 7.2	11.2 / 9.5
Dental		
Dentist	4.4 / 3.7	6.5 / 5.7
Dental Specialists		
Oral Surgeon	36.6 / 32.0	39.8 / 34.6
Orthodontist	34.1 / 27.8	47.2 / 37.6
Periodontist	111.8 / 76.4	111.8 / 76.4
Pediadontist	13.9 / 11.8	18.2 / 15.5

*For some members, the nearest in-network providers may be out of state.
**High-volume specialists are those identified by DHHS for purposes of the time and distance analysis.

Recommendations Over the Past Year Based on Information Gathered During the Validation Process

Molina was a new MCO to Nebraska as of January 1, 2024; therefore, HSAG did not have recommendations over the past year based on information gathered during the validation process.

Strengths

Molina had processes to maintain accuracy and completeness of member data by performing pre- and post-load data validation, and a reconciliation process using exception reports to address discrepancies. **[Access]**

Molina had processes in place to maintain provider data, including the use of iServe to track provider data requests to completion, a quality control process to audit provider updates, and vendors to assist in validating provider data accuracy. **[Access]**

Molina had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has *High Confidence* in **Molina**'s ability to produce accurate results to support its own and the State's network adequacy monitoring efforts. **[Access]**

Molina provided at least 99 percent of members access within standards for a majority of provider type and urbanicity combinations (26 of 39). **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

Molina identified network adequacy challenges it had encountered, including establishing operations in a new market with new staff members who were continuing to learn their roles, systems, and processes, including using Quest Analytics. HSAG recommended that **Molina** leverage Quest Analytics to support onboarding and training with newer staff members using the program. **[Access]**

Molina identified network adequacy challenges within rural areas and across dental providers, which were corroborated by HSAG's time and distance analysis. HSAG recommended that **Molina** continue to explore best practices and incentive programs that other organizations may have used to increase access. In addition, **Molina** should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed. **[Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, or PAHP, has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. However, **Molina** was a new MCO to Nebraska as of January 1, 2024; therefore, **Molina** did not have prior year recommendations from the EQRO.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Plan All-Cause Readmissions*

NTC submitted the clinical PIP, *Plan All-Cause Readmissions*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions* measure, for the CY 2024–2025 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For the second validation rating, HSAG assigned a level of *No Confidence* that the PIP achieved significant improvement. HSAG assigned a level of *No Confidence* for Validation Rating 2 because the performance indicator results demonstrated a decline in performance from baseline to the third remeasurement. Table B-1 summarizes NTC's PIP validation scores.

Table B-1—2024–2025 PIP Validation Results for NTC

		Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
PIP Topic	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Plan All-Cause Readmissions	Initial Submission	87%	89%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

Overall, 100 percent of all applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP received a score of *Met*. Table B-2 presents baseline, Remeasurement 1, Remeasurement 2, and Remeasurement 3 performance indicator data for **NTC**'s *Plan All-Cause Readmissions* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table B-2—Performance Indicator Results for NTC's *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Remeasurement 3 (01/01/2023 to 12/31/2023)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 175 D: 1,589	11.01%	N: 254 D: 1,942	13.08%	N: 323 D: 2,795	11.56%	N: 329 D: 2,839	11.59%	*Not Assessed*

N–Numerator D–Denominator

For the baseline measurement period, **NTC** reported that 11.01 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. For the first remeasurement period, **NTC** reported that 13.08 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The increase in the total observed readmission rate of 2.07 percentage points represented a decline in indicator performance from baseline to Remeasurement 1.

For the second remeasurement period, **NTC** reported that 11.56 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 2 rate was an improvement (decrease) of 1.52 percentage points from the Remeasurement 1 rate; however, the Remeasurement 2 rate did not improve over the baseline results. The increase of 0.55 percentage point from the baseline rate to the Remeasurement 2 rate represented a decline in indicator performance compared to initial indicator results.

For the third remeasurement period, **NTC** reported that 11.59 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 3 rate was a decline (increase) of 0.03 percentage points from the Remeasurement 2 rate. The Remeasurement 3 rate also represented a decline in indicator performance compared to the initial indicator results reported in the baseline period. There was a reported increase of 0.58 percentage point from the baseline rate to the Remeasurement 3 rate.

Nonclinical PIP: *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*

NTC submitted the nonclinical PIP, *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*, focused on improving performance in the percentage of deliveries for **NTC** members for whom a completed NOP form was received 252 days prior to delivery for the HEDIS *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* measure, for the CY 2024–2025 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. HSAG assigned a *High Confidence* level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the second remeasurement. The second remeasurement results also demonstrated sustained improvement as statistically significant improvement over baseline was demonstrated for two consecutive remeasurement periods. Table B-3 summarizes **NTC**'s PIP validation scores.

Table B-3—2024–2025 PIP Validation Results for NTC

		Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
PIP Topic	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate	Initial Submission	88%	89%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

Overall, 100 percent of all applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP received a score of *Met*. Table B-4 presents baseline, Remeasurement 1, and Remeasurement 2 performance indicator data for **NTC**'s *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP, which was used to objectively assess for improvement.

Table B-4—Performance Indicator Results for NTC's *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP

Performance Indicator	Baseline (01/01/2021 to 12/31/2021)		Remeasurement 1 (01/01/2022 to 12/31/2022)		Remeasurement 2 (01/01/2023 to 12/31/2023)		Sustained Improvement
The percentage of deliveries for NTC members for whom a completed NOP form was received 252 days prior to delivery.	N: 1,704 D: 3,007	56.7%	N: 1,768 D: 2,956	59.81%	N: 1,982 D: 3,069	64.58%	*Yes*

N–Numerator D–Denominator

For the baseline measurement period, NTC reported that 56.7 percent of deliveries had a NOP form completed 252 days prior to delivery. For the first remeasurement period, NTC reported that 59.81 percent of deliveries had a NOP form completed 252 days prior to delivery. The increase of 3.11 percentage points demonstrated a statistically significant improvement in the NOP completion rate from baseline to Remeasurement 1.

For the second remeasurement period, NTC reported that 64.58 percent of deliveries had a NOP form completed 252 days prior to delivery. The increase of 7.91 percentage points demonstrated a statistically significant ($p < 0.0001$) improvement in the NOP completion rate from baseline to Remeasurement 2.

Interventions

Clinical PIP: *Plan All-Cause Readmissions*

For the *Plan All-Cause Readmissions* PIP, NTC used brainstorming, a 5 Whys root cause analysis, and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table B-5 displays the barriers and interventions documented by NTC for the PIP.

Table B-5—Barriers and Interventions for the *Plan All-Cause Readmissions* PIP

Barriers	Interventions
Lack of timely notification of member's hospital admission and discharge.	Analysis of the admission, discharge, and transfer (ADT) system feed for timely identification of member admissions and discharges.
Members are difficult to reach for follow-up appointments following a hospital discharge.	Face-to-face visit by case management manager and/or physical health (PH) case manager for transition of care (TOC) planning with member prior to discharge from an inpatient PH hospitalization.

Barriers	Interventions
Additional support needed to reduce readmissions for members with behavioral health (BH) diagnoses.	Face-to-face visit by BH manager and/or BH case manager to schedule follow-up appointment with member prior to discharge from an inpatient BH hospitalization.
	Licensed BH staff outreach to member prior to and following discharge from an inpatient BH hospitalization.

Nonclinical PIP: *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate*

For the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP, **NTC** used brainstorming, a 5 Whys root cause analysis, and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table B-6 displays the barriers and interventions documented by **NTC** for the PIP.

Table B-6—Barriers and Interventions for the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP

Barriers	Interventions
Unable to reach members who may be pregnant.	Automated outreach calls and emails delivered to members listed on the 413 report (possible pregnancy report) encouraging NOP completion, if applicable.
Members not motivated by original incentive amount to complete NOP.	Revised and increased member incentive for NOP completion in 2023.
Providers need reminders to complete NOPs.	Developed strategic plan for provider education on NOP incentive for 2023.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **NTC** followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **NTC** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **NTC** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**
- **NTC** reported Remeasurement 2 indicator results for the *Maternal Child Health—Increasing Notification of Pregnancy (NOP) Rate* PIP that demonstrated statistically significant and sustained improvement over baseline results. **[Quality and Timeliness]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG identified the following opportunity for improvement:

- **NTC** reported Remeasurement 3 indicator results for the *Plan All-Cause Readmissions* PIP that demonstrated a decline in performance improvement from baseline despite an improvement from Remeasurement 1. **[Quality]**

To address the opportunity for improvement, HSAG offers the following recommendations for **NTC**:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use PDSA cycles or other methodologically sound processes to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table B-7 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table B-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendation
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Response
Describe initiatives implemented based on recommendations: *NOP [Notification of Pregnancy] PIP: reflects that Barrier and Intervention Analysis include review of barriers and root cause using 5 Why's.* Based on review of Barriers within NOP PIP the Health Plan changed the member incentive adding the following: • MyHealth Pays monetary rewards   ○ Reward was revised to reflect enhanced rewards to a value add of various member gifts based on re-evaluation of root analysis (5 Why's) • Marketing / communication of existing Provider NOP incentive • Additional marketing/ communication of existing Provider NOP incentive using newsletters, digital communication and Quality Practice Advisors.

PCR [Plan All-Cause Readmissions] PIP: Fishbone Diagram barrier analysis used in addition to a root cause analysis using 5 Why's during 2021 and 2022.

From the initial barrier analysis the following focused barriers were identified for initiative development:

- member support post discharge, using Transition of Care (TOC) process.
- Enhanced referral process from UM to CM.
- Member outreach to complete the transition of care assessment, updating the transition of care workflow and training of staff and review and updating of the UM and CM referral process.
    - Transition of Care Coordinator position was put in place with BH licensure based on 5 Why root cause evaluation. Second TOC position put in place after evaluation of TOC initiative metrics and success.
- UNMC partnership with outreach to Schizophrenic Population (based on re-evaluation of root cause using 5 Whys')
- ADT report re-evaluation and report revisions (implemented based on re-evaluation of 5 Why's)

Annual re-evaluation of Barriers / Root Cause using 5 Why's

- 2022 Re-evaluation identified the following:
    - Right person needing to do TOC, the initiative was training of UM to CM referrals for better outreach and successful monitoring.
    - Provider education barrier with initiative of news article related to PCR and opportunities to improve.
    - Further understanding of PCR data based on measure specifications led to initiative of data analysis of previous years data.
    - Barrier was BH support needed to reduce readmissions with initiative created was partnership with UNMC Psychiatry program outreaching post discharge to members who were schizophrenic.

- 2023 Re-evaluation identified the following:
    - Identification of getting better and more usable ADT data from HIE Cync Health data through analysis of PCR HEDIS population.
    - BH members need of support post discharge continued to focus on initiative of having a dedicated Transition of Care Coordinator outreaching to these members.
    - Related to barrier of difficulty in contacting members led to face-to-face Case Management (CM) with a high volume BH provider.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Notice of Pregnancy PIP – Goal met

Total Rate Changes
Q1 2023 Rate (61.83%) increased by 9.03% improvement from Q4 2022 quarter.
Q2 rate improved by 7.12% over 2022 baseline(65.23%).
Q3 posted a 65.13% (3.94 improvement over 2022) with member value adds claimed; and Provider promotion and awareness of incentive programs; Q4 had a increase rate of 66.9 (which was - 0.56 below Q4 2022 rate).

- Promoting established Provider NOP incentives led to substantial increase in year over year submissions from 2021 – 2023. (refer to PIP for Metrics)

- Member incentive change to a revised value add added substantial increase in member NOP submissions. Member marketing / website enhancements and case management work with members added to awareness also. (refer to PIP for Metrics)

PCR PIP: Goal not met.

Though this goal was not met during PIP period, the PDSA process completed for this PIP allowed for sustainable interventions with a long-term success in meeting goal in current 2024 data.

Noticeable improvements in PCR were reflected in the following interventions:

- Initiation of Transition of Care position(s) that were license BH professionals and care coordination of members with transition / discharge planning or post discharge needs.
- Evaluation and enhancements of HIE Cync ADT data allowed for better reports for member outreach.
- Face to Face BH and PH CM support within identified hospitals assisting members with care coordination and support health facilities.
- UNMC Dept of Psychiatry outreach with Schizophrenic population.
- Ongoing PCR data analysis (yearly) helped identified targeted population for outreach.

Identify any barriers to implementing initiatives:

Based on annual barrier analysis and root cause evaluation using 5 Why's the plan identified the following barriers to implementing initiatives.

NOP PIP 2021-2023

- 2023 Interventions #1: My Health Pays Dollar Value Add. Barrier Getting the information to members for which intervention applicable.
- 2023 Intervention #2: Provider NOP reminders. The identified barrier for this initiative is that not all providers may receive direct communication from Health Plan staff.

PCR PIP Intervention

- 2022 member outreach intervention: Identified ADT feed from state HIE needed enhancements to better capture member information related to Admissions, discharges and transfers.
- 2022 member support and outreach intervention: identified that members being outreach were predominately behavioral health which required CM staff with skill set and licensure to work with population.
- 2022 member outreach intervention: identified workflow issues and need to revise resources

Identify strategy for continued improvement or overcoming identified barriers:

Overall Quality Strategy

- Continued use of A3 & process improvement tools with process improvement work.
- Continue to incorporate Health Plan identified Workstreams which are interdepartmental and interdisciplinary teams to focus on key Performance improvement.
- Continue to analyze data to look for opportunities to improve data quality and evaluate opportunities within Provider groups, and member populations.
- Continue to monitor data for Health Equity opportunities evaluating for Zip, language, race & Ethnicity and gender.

NOP PIP Strategy

- Continue to provide ongoing provider messaging and member messaging related to incentives.

- Evaluate Member incentives and provider incentives based on feedback.
- Continue to educate CM and other health plan staff related to NOP process and benefits.

PCR PIP Strategy

Continued strategy to improve PCR outcomes related to this PIP and / or overcoming barriers include:

- Continued use of A3 methodology in managing performance improvement using interdisciplinary team.
- Continued use of TOC Behavioral Health CM team in helping establish the trust and engagement of the BH member and assisting members with any needs post discharge / transition. Based on success of initial position, the health plan added a second.

Expansion of face-to-face Case Management engagement with members and providers pre-discharge. The benefits of this program have shown a reduction in readmissions but also established coordination of care and collaborative relationships with providers / facilities.

HSAG Assessment:

NTC sufficiently addressed the CY 2023–2024 recommendation.

Recommendation

Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.

Response

Describe initiatives implemented based on recommendations:

NOP PIP: reflects that Barrier and Intervention Analysis include review of barriers and root cause using 5 Why's.

Based on review of Barriers within NOP PIP the Health Plan changed the member incentive adding the following:

- MyHealth Pays monetary rewards
  - Reward was revised to reflect enhanced rewards to a value add of various member gifts based on re-evaluation of root analysis (5 Why's)
- Marketing / communication of existing Provider NOP incentive
- Case Management Outreach and completion of NOP
  - Additional marketing/ communication of existing Provider NOP incentive using newsletters, digital communication and Quality Practice Advisors.

PCR PIP: Fishbone Diagram barrier analysis used in addition to a root cause analysis using 5 Why's during 2021 and 2022.

From the initial barrier analysis the following focused barriers were identified for initiative development:

- member support post discharge, using Transition of Care (TOC) process.
- Enhanced referral process from UM to CM.
- Member outreach to complete the transition of care assessment, updating the transition of care workflow and training of staff and review and updating of the UM and CM referral process.
  - Transition of Care Coordinator position was put in place with BH licensure based on 5 Why root cause evaluation. Second TOC position put in place after evaluation of TOC initiative metrics and success.

- UNMC partnership with outreach to Schizophrenic Population (based on re-evaluation of root cause using 5 Whys')
- ADT report re-evaluation and report revisions (implemented based on re-evaluation of 5 Why's)

Annual re-evaluation of Barriers / Root Cause using 5 Why's

- 2022 Re-evaluation identified the following:
  - Right person needing to do TOC, the initiative was training of UM to CM referrals for better outreach and successful monitoring.
  - Provider education barrier with initiative of news article related to PCR and opportunities to improve.
  - Further understanding of PCR data based on measure specifications led to initiative of data analysis of previous years data.
  - Barrier was BH support needed to reduce readmissions with initiative created was partnership with UNMC Psychiatry program outreaching post discharge to members who were schizophrenic.

- 2023 Re-evaluation identified the following:
  - Identification of getting better and more usable ADT data from HIE Cync Health data through analysis of PCR HEDIS population
  - BH members need of support post discharge continued to focus on initiative of having a dedicated Transition of Care Coordinator outreaching to these members
  - Related to barrier of difficulty in contacting members led to face-to-face Case Management (CM) with a high volume BH provider.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

NOP PIP – Goal met

Total Rate Changes

Q1 2023 Rate (61.83%) increased by 9.03% improvement from Q4 2022 quarter.
Q2 rate improved by 7.12% over 2022 baseline(65.23%).
Q3 posted a 65.13% (3.94 improvement over 2022) with member value adds claimed; and Provider promotion and awareness of incentive programs; Q4 had an increase rate of 66.9 (which was - 0.56 below Q4 2022 rate).

- Promoting established Provider NOP incentives led to noticeable increase in year over year submissions from 2021 – 2023. (refer to PIP for Metrics)
- Member incentive change to a revised value add added noticeable increase in member NOP submissions. Member marketing / website enhancements and case management work with members added to awareness also. (refer to PIP for Metrics)

PCR PIP: Goal not met.

Though this goal was not met during the PIP period, the PDSA process completed for this PIP allowed for sustainable interventions with a long-term success in meeting goal in current 2024 data.

Noticeable improvements in PCR were reflected in the following interventions:

- Initiation of Transition of Care position(s) that were license BH professionals and care coordination of members with transition / discharge planning or post discharge needs.
- Evaluation and enhancements of HIE Cync ADT data allowed for better reports for member outreach.

- Face to Face BH and PH CM support within identified hospitals assisting members with care coordination and support health facilities.
- Ongoing PCR data analysis (yearly) helped identified targeted population for outreach.

Identify any barriers to implementing initiatives:
Based on annual barrier analysis and root cause evaluation using 5 Why's the plan identified the following barriers to implementing initiatives.

NOP PIP 2021-2023

- 2023 Interventions #1: My Health Pays Dollar Value Add. Barrier Getting the information to members for which intervention applicable.
- 2023 Intervention #2: Provider NOP reminders. The identified barrier for this initiative is that not all providers may receive direct communication from Health Plan staff.

PCR PIP Intervention

- 2022 member outreach intervention: Identified ADT feed from state HIE needed enhancements to better capture member information related to Admissions, discharges and transfers.
- 2022 member support and outreach intervention: identified that members being outreach were predominately behavioral health which required CM staff with skill set and licensure to work with population.
- 2022 member outreach intervention: identified workflow issues and need to revise resources

Identify strategy for continued improvement or overcoming identified barriers:
[this area was left blank by the MCO]

HSAG Assessment:
NTC sufficiently addressed the CY 2023–2024 recommendation.

Recommendation

Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Response

Describe initiatives implemented based on recommendations:
NOP PIP: Use of Barrier and Intervention Analysis, Root Cause Analysis and 5 Why's.

Based on review of Barriers within NOP PIP **Nebraska Total Care** revised the member incentive, adding the following:

- MyHealth Pays monetary rewards.
- Marketing / communication of existing Provider NOP incentive.
- Additional marketing/ communication of existing Provider NOP incentive using newsletters, digital communication and Quality Practice Advisors.

PCR PIP: Use of Fishbone Diagram Barrier Analysis, Root Cause Analysis, and 5 Why's.

From the initial barrier analysis, the following focused barriers were identified for initiative development:

- Member support post discharge, using Transition of Care (TOC) process.

- Enhanced referral process from UM to CM.
- Member outreach to complete the TOC assessment, updating the TOC workflow, and training staff for review and updates to the UM and CM referral process.
    - Transition of Care Coordinator position was put in place with BH licensure based on 5 Why root cause evaluation. Second TOC position was put in place after evaluation of TOC initiative metrics and success.
- UNMC partnership with outreach to Schizophrenic Population.
- ADT report re-evaluation and report revisions.

Annual re-evaluation of barriers and root cause using 5 Why's:

- 2022 Re-evaluation identified the following:
    - Need to address the right person conducting TOC and implementing a training initiative for UM to CM referrals for better outreach and successful monitoring.
    - Address provider education barriers through initiatives like publishing news articles related to PCR and additional opportunities to improve.
    - Further understanding of PCR data based on measure specifications led to the initiative of data analysis from prior years data.
    - Initiate a partnership with UNMC Psychiatry program to address the barrier for additional BH support to reduce readmissions.

- 2023 Re-evaluation identified the following:
    - Identification of getting better and more usable ADT data from HIE Cync Health data through analysis of PCR HEDIS population.
    - BH members need of support post discharge continued to focus on initiative of having a dedicated Transition of Care Coordinator outreaching to these members.
    - Related to barrier of difficulty in contacting members led to face-to-face Case Management (CM) with a high volume BH provider.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
Notice of Pregnancy PIP – Goal met

Total Rate Changes
Q1 2023 Rate (61.83%) increased by 9.03% improvement from Q4 2022 quarter.
Q2 rate improved by 7.12% over 2022 baseline(65.23%).
Q3 posted a 65.13% (3.94 improvement over 2022) with member value adds claimed; and Provider promotion and awareness of incentive programs; Q4 had an increased rate of 66.9% (which was - 0.56 below Q4 2022 rate).

- Promoting established Provider NOP incentives led to substantial increase in year over year submissions from 2021 – 2023. (refer to PIP for Metrics)
- Member incentive changed to a revised value add resulting in a substantial increase in member NOP submissions. Member marketing and website enhancements along with case management work with members increased member awareness. (refer to PIP for Metrics)

PCR PIP: Goal not met.

Though this goal was not met during the PIP period, the PDSA process completed for this PIP allowed for sustainable interventions with a long-term success in meeting this goal noted in current 2024 data.

Noticeable improvements in PCR were reflected in the following interventions:

- Initiation of Transition of Care position(s) including licensed BH professionals, to support care coordination for members with transition and/or discharge planning, as well as post discharge needs.
- Evaluation and enhancements of HIE Cync ADT data allowed improved reports for member outreach.
- Implemented Face to Face BH and PH CM support within identified hospitals, assisting members with care coordination and furthering support for health facilities.
- UNMC Dept of Psychiatry outreach with Schizophrenic population.

Ongoing annual PCR data analysis, further supported in identifying targeted populations for outreach.

Identify any barriers to implementing initiatives:
Based on annual barrier analysis and root cause evaluation using 5 Why's the plan identified the following barriers to implementing initiatives.

NOP PIP 2021-2023

- 2023 Interventions #1: My Health Pays Dollar Value Add. Barrier Getting the information to members for which intervention applicable.
- 2023 Intervention #2: Provider NOP reminders. The identified barrier for this initiative is that not all providers may receive direct communication from Health Plan staff.

PCR PIP Intervention

- 2022 member outreach intervention: Identified that the ADT feed from state HIE needed enhancements to better capture member information related to admissions, discharges, and transfers.
- 2022 member support and outreach intervention: Identified that members receiving outreach were predominately identified as having behavioral health need, further requiring CM staff with BH skill set and licensure to work with populations.
- 2022 member outreach intervention: identified workflow issues and need to revise resources.

Identify strategy for continued improvement or overcoming identified barriers:
Overall Quality Strategy

- Continued use of A3 and process improvement tools with process improvement work.
- Consistent incorporation of multidisciplinary Health Plan workstreams to focus on key performance improvements.
- Ongoing data analysis to identify opportunities for improving data quality along with evaluation of provider groups and member populations.
- Regularly monitor data for health equity opportunities like evaluating for zip code, language, race & Ethnicity, as well as gender.

NOP PIP Strategy

- Continue to provide ongoing provider messaging and member messaging related to incentives.
- Utilize feedback to further evaluate member and provider incentives.
- Continue to educate CM and other health plan staff related to the NOP process and its benefits.

PCR PIP Strategy
Continued strategy to improve PCR outcomes related to this PIP and overcoming barriers include:

• Continued use of A3 methodology in managing performance improvement using interdisciplinary team. • Continued use of TOC Behavioral Health CM team in helping establish trust and engagement of BH members and assisting members with needs post discharge and transition. Based on success of initial position, the health plan added a second TOC position. • Expansion of face-to-face Case Management engagement with members and providers pre-discharge. The benefits of this program have shown a reduction in readmissions but also established coordination of care and collaborative relationships with providers and facilities.
HSAG Assessment: NTC sufficiently addressed the CY 2023–2024 recommendation.

Validation of Performance Measures

Results for Information Systems Standards Review

Table B-8 provides a summary of NTC's key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix D* of this report.

Table B-8—Summary of Compliance With IS Standards for NTC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software.	NTC was compliant with IS Standard R for data management and reporting. The LO determined that NTC had procedures in place so that all data elements required for HEDIS reporting were adequately captured. The LO determined that the MCO had policies and procedures in place for validation of data extraction, transformation, and integration. The LO determined that NTC was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	NTC was compliant with IS Standard C for clinical and care delivery data. The LO determined that NTC had policies and procedures in place for submitted data that conform with industry standards. Adequate validation processes were in place, ensuring data accuracy and quality.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
IS M—Medical Record Review Processes • IS M1—Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off). • IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. • IS M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	**NTC** was compliant with IS Standard M for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	**NTC** was compliant with IS Standard A for administrative data. The LO determined that the MCO appropriately validated that data conform with industry standards and measure requirements. The LO reviewed the membership information system to ensure that it appropriately enables measurement. Sufficient validation processes were in place to ensure that data are accurate and complete.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **NTC**. According to the DHHS' required data collection methodology, the rates displayed in Table B-9 reflect all final reported rates in **NTC**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **NTC** may have received an "*NA*" status for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table B-9—HEDIS Audit Results for NTC

Audit Finding	Description	Audit Result
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	***R***
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	***NA******
The MCO did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	***NB****
The MCO chose not to report the measure.	Not Reported	***NR***
The MCO was not required to report the measure.	Not Required	***NQ****
The rate calculated by the MCO was materially biased.	Biased Rate	***BR***
The MCO chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).	Unaudited	***UN***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).

**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table B-10—NTC's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Effectiveness of Care Domain: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Body Mass Index (BMI) Percentile Documentation—Total	69.34%	70.80% ★	71.53% ★	R
Counseling for Nutrition—Total	55.96%	65.69% ★★	64.96% ★★	R
Counseling for Physical Activity—Total	57.18%	67.64% ★★	62.04% ★★	R
Childhood Immunization Status (CIS)				
Combination 3	70.07%	71.29% ★★★★	68.61% ★★★	R
Combination 7	61.56%	63.26% ★★★★	60.58% ★★★★	R
Combination 10	47.45%	42.82% ★★★★	42.09% ★★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.10%	78.35% ★★	74.94% ★★	R
Combination 2 (Meningococcal, Tdap, HPV)	33.33%	27.49% ★	31.14% ★★	R
Lead Screening in Children (LSC)				
Lead Screening in Children	68.94%	68.15% ★★★	69.88% ★★★	R
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	58.39%	61.80% ★★★★	63.02% ★★★★	R
Chlamydia Screening in Women (CHL)				
Ages 16 to 20 Years	28.02%	31.45% ★	30.29% ★	R
Ages 21 to 24 Years	44.46%	42.16% ★	44.01% ★	R
Total	34.22%	36.07% ★	36.24% ★	R
Colorectal Cancer Screening (COL)				
Ages 46 to 50 Years	—	23.16% NC	29.51% ★★★	R
Ages 51 to 75 Years	—	38.19% NC	41.30% ★★	R
Total	—	34.92% NC	38.15% ★★★	R
Effectiveness of Care Domain: Respiratory Conditions				
Appropriate Testing for Pharyngitis (CWP)				
Ages 3 to 17 Years	70.31%	69.03% ★	80.49% ★★	R
Ages 18 to 64 Years	63.08%	63.02% ★★	74.30% ★★★	R
Ages 65 Years and Older	NA	NA	NA	R
Total	68.15%	67.15% ★★	78.78% ★★	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.41%	28.03% ★★★★	23.42% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	72.20%	72.50% ★★★	71.82% ★★★	R
Bronchodilator	87.89%	82.50% ★★	84.53% ★★★	R
Asthma Medication Ratio (AMR)				
Ages 5 to 11 Years	83.71%	82.67% ★★★★	80.16% ★★★	R
Ages 12 to 18 Years	72.69%	74.78% ★★★★	76.67% ★★★★	R
Ages 19 to 50 Years	62.29%	72.22% ★★★★★	73.16% ★★★★★	R
Ages 51 to 64 Years	59.26%	75.81% ★★★★★	80.83% ★★★★★	R
Total	71.99%	75.92% ★★★★★	76.50% ★★★★	R
Effectiveness of Care Domain: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	61.31%	67.64% ★★★★	63.99% ★★	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
Persistence of Beta-Blocker Treatment After a Heart Attack	76.67%	87.23% ★★★★	NA	R
Effectiveness of Care Domain: Diabetes				
Hemoglobin A1c Control for Patients with Diabetes (HBD)				
HbA1c Control (<8.0%)	51.82%	52.07% ★★	60.58% ★★★	R
*HbA1c Poor Control (>9.0%)**	39.90%	36.74% ★★★	27.25% ★★★★	R
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure <140/ 90 mm Hg	66.91%	69.59% ★★★	76.16% ★★★★	R
Eye Exam for Patients With Diabetes (EED)				
Eye Exam	57.66%	58.39% ★★★	56.20% ★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Effectiveness of Care Domain: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	64.57%	62.14% ★★★	62.91% ★★★	R
Effective Continuation Phase Treatment	47.12%	45.37% ★★★	44.41% ★★★	R
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	47.12%	43.99% ★★	47.19% ★★★	R
Continuation and Maintenance Phase	48.39%	54.15% ★★★	53.82% ★★★	R
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Ages 6 to 17 Years	46.12%	60.04% ★★★★	70.62% ★★★★★	R
30-Day Follow-Up—Ages 6 to 17 Years	68.98%	78.59% ★★★★	84.94% ★★★★★	R
7-Day Follow-Up—Ages 18 to 64 Years	29.22%	35.06% ★★★	45.66% ★★★★	R
30-Day Follow-Up—Ages 18 to 64 Years	47.10%	54.78% ★★★	62.15% ★★★	R
7-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA	R
30-Day Follow-Up—Ages 65 Years and Older	NA	NA	NA	R
7-Day Follow-Up—Total	34.49%	42.09% ★★★	52.15% ★★★★	R
30-Day Follow-Up—Total	53.92%	61.43% ★★★	68.10% ★★★	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	43.33%	39.42% ★★	40.22% ★★★	R
30-Day Follow-Up—Total	61.39%	59.61% ★★★	58.57% ★★★	R
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7-Day Follow-Up—Total	25.08%	29.56% ★★	26.94% ★★	R
30-Day Follow-Up—Total	42.52%	47.50% ★★	44.08% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	29.34% NC	26.23% ★★★	R
30-Day Follow-Up—Total	—	43.47% NC	41.65% ★★★	R
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.96%	79.60% ★★★	84.65% ★★★★	R
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	65.48%	61.82% ★	73.74% ★★★	R
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	NA	R
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.82%	61.39% ★★★	62.79% ★★★	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose—1 to 11 Years	—	39.19% ★★	47.58% ★★★	R
Blood Glucose—12 to 17 Years	—	59.46% ★★	60.95% ★★	R
Blood Glucose—Total	—	52.48% ★★	55.99% ★★	R
Cholesterol—1 to 11 Years	—	25.36% ★★	34.95% ★★★	R
Cholesterol—12 to 17 Years	—	34.80% ★★	39.52% ★★	R
Cholesterol—Total	—	31.55% ★★	37.82% ★★★	R
Blood Glucose and Cholesterol—1 to 11 Years	—	22.19% ★	31.99% ★★★	R
Blood Glucose and Cholesterol—12 to 17 Years	—	32.53% ★★	37.62% ★★	R
Blood Glucose and Cholesterol—Total	—	28.97% ★★	35.53% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Effectiveness of Care Domain: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.64%	0.48% ★★	0.45% ★★	R
Appropriate Treatment for Upper Respiratory Infection (URI)				
Ages 3 Months to 17 Years	89.58%	89.72% ★	89.12% ★	R
Ages 18 to 64 Years	79.40%	81.86% ★★★	79.21% ★★	R
Ages 65 Years and Older	NA	NA	78.13% ★★★	R
Total	87.75%	88.04% ★	87.01% ★★	R
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	74.09% NC	71.89% ★★★	R
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage (Average MME ≥90)**	2.39%	2.04% ★★★	1.53% ★★★	R
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
Ages 3 Months to 17 Years	—	73.33% ★★★	73.63% ★★★	R
Ages 18 to 64 Years	—	39.39% ★★	36.62% ★	R
Ages 65 Years and Older	—	NA	NA	R
Total	—	63.17% ★★★	63.49% ★★★	R
Access/Availability of Care Domain				
Initiation and Engagement of SUD Treatment (IET)				
Initiation of SUD Treatment—Total—Ages 13 to 17 Years	—	29.91% NC	30.14% ★	R
Engagement of SUD Treatment—Total—Ages 13 to 17 Years	—	12.25% NC	16.90% ★★★★	R
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	—	39.97% NC	36.43% ★	R
Engagement of SUD Treatment—Total—Ages 18–64 Years	—	12.62% NC	10.20% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Initiation of SUD Treatment—Total—Ages 65 Years and older	—	NA	NA	R
Engagement of SUD Treatment—Total—Ages 65 Years and older	—	NA	NA	R
Initiation of SUD Treatment—Total—Total	—	38.98% NC	35.85% ★	R
Engagement of SUD Treatment—Total—Total	—	12.57% NC	10.80% ★★	R
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	77.86%	83.45% ★★	77.62% ★	R
Postpartum Care	76.16%	79.08% ★★★	76.89% ★★	R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Ages 1 to 11 Years	—	57.97% ★★★	56.95% ★★	R
Ages 12 to 17 Years	—	55.30% ★★	65.24% ★★★	R
Total	—	56.22% ★★	61.98% ★★★	R
Utilization and Risk Adjusted Utilization Domain: Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	65.23%	67.06% ★★★★	71.10% ★★★★★	R
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.85%	70.09% ★★★	73.38% ★★★★	R
Ambulatory Care (Per 1,000 Member Years) (AMB)				
*Emergency Department Visits—Total**	626.52	641.26 ★★★	611.97 ★★★	R
Outpatient Visits, Including Telehealth—Total	4,329.72	4,312.27 NC	4,273.13 NC	R
Inpatient Utilization—General Hospital/Acute Care (IPU)[1]				
Discharges per 1,000 Member Years—Total Inpatient—Total	82.08	69.52 NC	66.52 NC	R
Average Length of Stay—Total Inpatient—Total	5.08	5.44 NC	5.24 NC	R
Discharges per 1,000 Member Years—Maternity—Total	47.64	38.41 NC	35.94 NC	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Average Length of Stay—Maternity—Total	2.66	2.65 NC	2.73 NC	R
Discharges per 1,000 Member Years—Surgery—Total	17.88	16.37 NC	16.24 NC	R
Average Length of Stay—Surgery—Total	9.59	10.51 NC	9.39 NC	R
Discharges per 1,000 Member Years—Medicine—Total	33.96	27.68 NC	26.29 NC	R
Average Length of Stay—Medicine—Total	4.87	5.01 NC	4.97 NC	R
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	—	49.40% ★	53.48% ★	R
Ages 12 to 17 Years	—	52.79% ★★★	56.42% ★★★	R
Ages 18 to 21 Years	—	21.56% ★★	26.37% ★★	R
Total	—	46.14% ★★	50.54% ★★	R
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—18–64**	13.08%	11.61% NC	11.76% NC	R
*Expected Readmissions—18–64**	10.90%	10.83% NC	10.34% NC	R
*O/E Ratio—18–64**	1.20	1.0718 ★	1.1380 ★	R
Measures Reported Using ECDS				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	—	54.41% NC	56.96% ★★★	R
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.19% ★★	0.61% ★★	R
Follow-Up on Positive Screen	—	NA	NA	R
Postpartum Depression Screening and Follow-Up (PDS-E)				

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Depression Screening	—	0.11% ★★★	0.43% ★★	R
Follow-Up on Positive Screen	—	NA	NA	R

[1] In the *Utilization* domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for information only.
* For this indicator, a lower rate indicates better performance.
NA indicates that the MCO(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2023 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO(s).
HEDIS MY 2023 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-11—NTC's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate
CMS Adult Core Measures Set			
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)			
Use of Pharmacotherapy for Opioid Use Disorder—Total (Rate 1)	37.93%	57.44%	59.02%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)			
*Ages 18 to 64**	3.53%	1.89%	1.79%
*Age 65 and Older **	1.41%	0.00%	0.00%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)			
Ages 18 to 64	—	—	—
Age 65 and Older	—	—	—
Concurrent Use of Opioids and Benzodiazepines (COB-AD)			
*Ages 18 to 64**	21.31%	18.43%	19.33%
*Age 65 and Older **	16.25%	16.18%	11.54%
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)			
Ages 21 to 44: Most or Moderately Effective Contraception—Within 3 Days of Delivery	—	—	10.13%
Ages 21 to 44: Most or Moderately Effective Contraception—Within 90 Days of Delivery	—	—	45.86%
Ages 21 to 44: Long-Acting Reversible Method of Contraception (LARC)—Within 3 Days of Delivery	—	—	0.83%

CMS Core Set Measures	MY 2021 Rate	MY 2022 Rate	MY 2023 Rate
Ages 21 to 44: LARC—Within 90 Days of Delivery	—	—	17.71%
CMS Child Core Measures Set			
Developmental Screening in the First Three Years of Life (DEV-CH)			
Children Who Turned 1 Year	24.22%	25.89%	27.75%
Children Who Turned 2 Years	31.23%	32.80%	34.16%
Children Who Turned 3 Years	29.72%	28.61%	32.28%
Total	28.26%	29.05%	31.39%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)			
Ages 12 to 17	—	—	—
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)			
Ages 15 to 20: Most or Moderately Effective Contraception—Within 3 Days of Delivery	—	1.98%	3.45%
Ages 15 to 20: Most or Moderately Effective Contraception—Within 90 Days of Delivery	—	40.48%	58.62%
Ages 15 to 20: LARC—Within 3 Days of Delivery	—	1.59%	2.07%
Ages 15 to 20: LARC—Within 90 Days of Delivery	—	20.63%	26.90%
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)			
Ages 15 to 20: Were Provided a Most Effective or Moderately Effective Method of Contraception	—	28.50%	28.81%
Ages 15 to 20: Were Provided a LARC	—	4.70%	5.31%

* For this indicator, a lower rate indicates better performance
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.

Strengths

Effectiveness of Care Domain: Prevention and Screening

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*; *Lead Screening in Children*; *Cervical Cancer Screening*; and *Colorectal Cancer Screening—Ages 46 to 50 Years* and *Total* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Childhood Immunization Status—Combination 7* and *Combination 10* and *Cervical Cancer Screening* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Childhood Immunization Status—Combination 3, Lead Screening in Children*, and *Colorectal Cancer Screening—Ages 46 to 50 Years* and *Total* measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-

threatening disease. The *Lead Screening in Children* rate demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they maintained limited exposure to lead. The *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 years were receiving screening for one of the most common causes of cancer death in the United States. Lastly, the *Colorectal Cancer Screening* rate demonstrates that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality, Timeliness, and Access]**

Effectiveness of Care Domain: Respiratory Conditions

The *Asthma Medication Ratio—Ages 12 to 18*, *Ages 19 to 50*, *Ages 51 to 64*, and *Total* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for these measure indicators. The *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years, Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator,* and *Asthma Medication Ratio—Ages 5 to 11 Years* measure indicators were also a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for these measure indicators. The *Asthma Medication Ratio* rates demonstrate that **NTC** providers effectively managed this treatable condition for members with persistent asthma. The *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years* rate demonstrates that **NTC** providers were appropriately prescribing antibiotics and ordering a group A streptococcus test for pharyngitis episodes. Lastly, the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* rates demonstrate that **NTC** providers were appropriately prescribing medication to help members control their COPD. **[Quality and Timeliness]**

Effectiveness of Care Domain: Diabetes

The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)*, *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)*, and *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* measure indicators were a strength **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and the *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)* measure indicators. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and the *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* measure indicators. The *Hemoglobin A1c Control for Patients With Diabetes* rates demonstrate that **NTC** providers helped members effectively control their blood glucose levels, reducing the risk of complications. The *Blood Pressure Control for Patients With Diabetes* rate demonstrates that **NTC** providers helped adult members with diabetes adequately control their blood pressure. Lastly, the *Eye Exam for Patients With Diabetes* rate demonstrates that **NTC** providers ensured that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care: Behavioral Health

For the following measure indicators, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* **[Quality]**
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* **[Quality, Timeliness, and Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64, and Total)* and *30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64, and Total)* **[Quality, Timeliness, and Access]**
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**
- *Diabetes Monitoring for People with Diabetes and Schizophrenia* **[Quality]**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **[Quality]**
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—1 to 11 Years, Cholesterol—1 to 11 Years* and *Total,* and *Blood Glucose and Cholesterol—1 to 11 Years* **[Quality]**

The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* rates demonstrate that **NTC** providers were effectively treating adult members diagnosed with major depression by prescribing antidepressant medication and helping them remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**

The *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* rates demonstrates that **NTC** providers ensured that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates demonstrate that **NTC** providers ensured that members hospitalized for mental illness received adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* and the *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* rates demonstrate that **NTC** providers effectively

managed care for patients discharged after an ED visit for mental illness and substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Furthermore, members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rate demonstrates that **NTC** providers effectively ensured that adult members on antipsychotics were screened for diabetes, resulting in positive health outcomes for this population. The *Diabetes Monitoring for People with Diabetes and Schizophrenia* rate demonstrates that **NTC** providers effectively ensured that adult members with schizophrenia and diabetes had appropriate testing completed annually to appropriately manage their diabetes. Additionally, the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rate demonstrates that **NTC** providers ensured that members with schizophrenia or schizoaffective disorder adhered their treatment plan and continued to use prescribed antipsychotic medications. **[Quality, Timeliness, and Access]**

Finally, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—1 to 11 Years, Cholesterol—1 to 11 Years* and *Total,* and *Blood Glucose and Cholesterol—1 to 11 Years* rates demonstrate that **NTC** providers effectively ensured that children and adolescents ages 1 to 11 years with ongoing antipsychotic medication use had appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**

Effectiveness of Care Domain: Overuse/Appropriateness

The *Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older*, *Use of Imaging Studies for Low Back Pain—Total, Use of Opioids at High Dosage,* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for these measure indicators. The *Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older* rate demonstrates that, for a subset of adult members, **NTC** providers effectively managed the dispensing of antibiotic medication to treat URI. The *Use of Imaging Studies for Low Back Pain—Total* demonstrates that **NTC** providers appropriately ordered imaging studies. The *Use of Opioids at High Dosage* rate demonstrates that **NTC** providers prevented or minimized the prescribing of opioids at a dosage of ≥90 mg morphine equivalent dose. The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* rates demonstrate that **NTC** providers effectively prevented or minimized the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**

Access/Availability of Care Domain

The *Engagement of SUD Treatment—Total—Ages 13 to 17 Years* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Ages 12 to 17 Years* and *Total* measure indicators were a strength for **NTC**. **NTC**'s rates for these measure indicators ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark. The *Engagement of SUD Treatment—Total—Ages 13 to 17 Years* rate demonstrates that **NTC** providers effectively engaged members with a new SUD episode in subsequent SUD services or medications

within 34 days of their visit to initiate SUD treatment. The *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Ages 12 to 17 Years* and *Total* rates indicate that **NTC** providers effectively utilized psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality, Timeliness, and Access]**

Utilization and Risk Adjusted Utilization Domain: Utilization

The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits, Ambulatory Care (Per 1,000 Member Years)—Emergency Department Visits—Total*, and *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicators were a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Ambulatory Care (Per 1,000 Member Years)—Emergency Department Visits—Total* and *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicators. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates show that **NTC** providers ensured that children were seen by a PCP within the first 30 months of life to assess and influence members' early development. The *Ambulatory Care (Per 1,000 Member Years)—Emergency Department Visits—Total* rate demonstrates that **NTC** providers ensured members received appropriate primary care to reduce preventable visits to the ED. The *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* rate indicates that **NTC** providers were effective in ensuring that adolescents received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

Measures Collected Using ECDS Domain

The *Breast Cancer Screening* measure was a strength for **NTC**. **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for this measure indicator. The rate for this measure indicator demonstrates that **NTC** providers were effective in ensuring that women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care Domain: Prevention and Screening

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. HSAG recommended that **NTC** and its providers strategize the best way to use every visit to encourage a healthy lifestyle and provide education on healthy habits for children and

adolescents. Additionally, HSAG recommended that **NTC** providers follow up annually with sexually active members through various modes of communication to ensure members return for a yearly screening. **[Quality]**

Effectiveness of Care: Overuse/Appropriateness

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark on these measure indicators. The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* rate suggests that a diagnosis of URI resulted in an antibiotic dispensing event for members 3 months to 17 years old. HSAG recommended that **NTC** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommended that **NTC** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. For the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years* measure indicator, HSAG recommended that **NTC** conducts data analysis across key demographics such as race, ethnicity, age, and ZIP Code to identify issues with antibiotics prescribing practices and implement targeted interventions. **[Quality]**

Access/Availability of Care Domain

The *Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. To improve the *Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* rates, HSAG recommended that **NTC** determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs. To improve the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate, HSAG recommended that **NTC** evaluate the feasibility of implementing appropriate interventions to improve the quality and accessibility of prenatal care. Best practices that **NTC** may consider implementing to improve prenatal care rates include offering provider education and engagement opportunities such as educational webinars and newsletters on prenatal health services and piloting a member incentives program designed to encourage timely prenatal care services. **[Quality, Timeliness, and Access]**

Utilization and Risk Adjusted Utilization Domain: Utilization

The *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* measure indicator was a weakness for **NTC**. The rate for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. Well-care visits provide an opportunity for physicians to provide screening and counseling. HSAG recommended that **NTC** implement targeted interventions based on identified disparities through ongoing data analysis and stratification across key

demographics such as race, ethnicity, age, and ZIP Code. HSAG also recommended that **NTC** identify best practices for ensuring children receive timely and medically appropriate well-care services. **[Quality and Access]**

Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization

The *Plan All-Cause Readmissions—Observed/Expected Ratio—Total* measure indicator was a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for this measure indicator. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. HSAG recommended that **NTC** work with its providers to ensure diagnosis and treatment of members are complete and precise to improve readmission rates. **[Quality]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-12 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table B-12—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendation **(Effectiveness of Care: Prevention and Screening Domain)**
The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. HSAG recommends that **NTC** and its providers strategize the best way to use every visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, HSAG recommends that **NTC** providers follow up annually with sexually active members through various modes of communication to ensure members return for yearly screening.
Response
Describe initiatives implemented based on recommendations: **WCC (Total)** • WCC within HEDIS dashboard for focused sub measures contains TIN level data that is shared with providers during visits with Quality Practice Advisors. • WCC BMI was a P4P in 2024. Data is shared on performance, during focused provider meetings. • SDS file data analysis is reviewed with the source provider, **Nebraska Total Care** Quality, and Corporate SDS team. If issues are identified, the health plan works with the provider to remediate. • Provider Education on BMI CPT II coding. • Annual Wellness visit messaging to members. • Provider P4P related to Wellness visits (W30). • Year-round provider chart submissions and uploads. **CHL** • Data Analysis of CHL measure data – comparing against tech specs, NE NAC and provider opportunities. • CHL education related specifications and data is shared during provider quality meetings. • CHL is a P4P in MY2024.

- Targeted member messaging is sent by the health plan.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

WCC
Resource: Run Over Run Dashboard
WCC
September Run 3 MY2023 (Prior Year) / September Run 3 MY2024 (Current Year)

State	Population	Measure	SubMeasure	Prior Num	Prior Den	Prior Rate	Current Num	Current Den	Current Rate	Current %ile Met	Rate Delta	Impact
NE	NE_MCD_EXCL_DUAL	wcc	all	7,609	30045	25.33%	7883	29273	26.93%	No QC Benchmark	1.60%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	all12_17	2,699	11142	24.22%	2818	10679	26.39%	No QC Benchmark	2.16%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	all3_11	4,910	18903	25.97%	5065	18594	27.24%	No QC Benchmark	1.27%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	bmi	13,402	30045	44.61%	13175	29273	45.01%	Less than 5th	0.40%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	bmi12_17	4,849	11142	43.52%	4770	10679	44.67%	Less than 5th	1.15%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	bmi3_11	8,553	18903	45.25%	8405	18594	45.20%	Less than 5th	-0.04%	Decrease
NE	NE_MCD_EXCL_DUAL	wcc	exer12_17	3,343	11142	30.00%	3417	10679	32.00%	Less than 5th	1.99%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	exer3_11	5,225	18903	27.64%	5440	18594	29.26%	Less than 5th	1.62%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	exercise	8,568	30045	28.52%	8857	29273	30.26%	Less than 5th	1.74%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	nut12_17	2,959	11142	26.56%	3057	10679	28.63%	Less than 5th	2.07%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	nut3_11	5,372	18903	28.42%	5602	18594	30.13%	Less than 5th	1.71%	Increase
NE	NE_MCD_EXCL_DUAL	wcc	nutrition	8,331	30045	27.73%	8659	29273	29.58%	Less than 5th	1.85%	Increase

CHL
Resource: Run Over Run Dashboard
CHL
September Run 3 MY2023 (Prior Year) / September Run 3 MY2024 (Current Year)

State	Population	Measure	SubMeasure	Prior Num	Prior Den	Prior Rate	Current Num	Current Den	Current Rate	Current %ile Met	Rate Delta	Impact
NE	NE_MCD_EXCL_DUAL	chl	age1620	600	2399	25.01%	548	2039	26.88%	Less than 5th	1.87%	Increase
NE	NE_MCD_EXCL_DUAL	chl	age2124	680	1939	35.07%	603	1575	38.29%	Less than 5th	3.22%	Increase
NE	NE_MCD_EXCL_DUAL	chl	total	1,280	4338	29.51%	1151	3614	31.85%	Less than 5th	2.34%	Increase

Identify any barriers to implementing initiatives:
WCC

1. Inconsistent submission of data due to staff and vendor changes of supplemental data, along with periodic changes in provider submissions.
2. Impact reporting of SDS files capture data from a hub that is based on other data sources, not including provider submitted data, resulting in unclear impact in relation to provider submitted data.

3. Provider documentation for WCC measures not meeting required documentation per HEDIS Technical Specifications based on Hybrid chart reviews.
4. WCC-BMI: Minimal CPT II coding is being done by providers in NE, with many providers stating they experience limitations withing the current EMR systems, along with little to no payment for CPT II coding.
5. In MY2023, Change Health Cyber incident created a massive disruption and shifting of priorities for HEDIS Hybrid season since Change was **Nebraska Total Care**'s primary chase vendor.
6. WCC-Nutrition: CPT code can only be submitted by Nutritionist provider type and Z Code cannot be independently submitted without being attached to an office visit.

CHL

1. Data Analysis of CHL measure showed a bundle code being used within the NAC, which includes several STI testing within one lab. Due to this bundled code not within the NCQA value set for CHL, those receiving CHL testing is not being captured.
2. Free clinics (public health, high school clinics, grant funding) are not submitting claims.
3. Providers are not billing CHL testing, in an effort to maintain a level of trust and privacy by omitting this test from being reported on EOBs.
4. Testing is being done within bundle billing for pregnant members.
5. CHL is not within the provider portal to upload charts.

Identify strategy for continued improvement or overcoming identified barriers:

WCC

1. Work with supplemental data submission (SDS) source providers and corporate SDS team to analyze file submissions and ensure appropriate data is captured.
2. Provider education on all sub measure documentation needs are done during quality visits, including TIN level data.
3. Conduct provider education on the benefits of CPT II codes for WCC BMI due to P4P opportunity and continue working with providers to understand timelines of CPTII implementation and EMR capabilities for ongoing maintaining and measuring of hybrid measures.
4. Developed internal processes to reduce the need for outside vendors for hybrid chart chase.
5. Investigate NCQA and corporate guidance on coding changes made according to NCQA value set for WCC Nutrition Counseling. Provide guidance to providers: Office visit must be attached to Z Code for measure closure (education provided).

CHL

1. Discuss the potential for building a custom measure for CHL that maps the bundle testing to CHL specifically.
2. Engage PHCO team with public health departments and HIE to capture CHL data from free clinics.
3. Analyze lab SDS file submissions to capturing CHL results and encourage providers to email or fax charts or CHL documentation, if they are not billing those tests.
4. Ongoing utilization of Obstetric Needs Assessment Forms (ONAF) to capture documented CHL within charting and accordingly, redesign a provider pregnancy initiative to include an incentive for submitting prenatal records. These records can be used for PPC timeliness, CHL, and CCS, measures (unable to capture via claims due to global billing).
5. Conduct year-round chart retrieval of ONAF submissions for identified pregnant members, as well as HIE records, and chart chases with analysis of SDS file submissions that evaluate potential optimization with source providers. This process will also encourage ongoing provider education that email and faxing charts is an option in lieu of the portal.

HSAG Assessment:

NTC did not sufficiently address the CY 2023–2024 recommendations regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. NTC's performance on this indicator was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. HSAG recognizes the initiatives NTC launched to improve performance on this indicator, including provider education, member messaging, and performance incentives, and recommends that NTC continue these efforts.

NTC did not sufficiently address the CY 2023–2024 recommendations regarding the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators. NTC's performance on these indicators was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. HSAG recognizes the initiatives NTC launched to improve performance on these indicators, including provider education, member messaging, and performance incentives, and recommends that NTC continue these efforts.

***Recommendation* (Effectiveness of Care: Respiratory Conditions Domain)**

The *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicator was a weakness for NTC. NTC's rate for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. The rate for this measure indicator suggests that child and adolescent members did not receive proper testing to merit antibiotic treatment for pharyngitis. HSAG recommends that NTC work with providers to determine whether children and adolescents are being properly tested to prevent the unnecessary use of antibiotics.

Response

Describe initiatives implemented based on recommendations:

NTC CWP data analysis showed providers were coding pharyngitis (unspecified) which inadvertently placed the member in the CWP measure.

Provider education has been conducted on CWP measures for all priority providers, with additional discussions on technical specifications, coding, and tips to improve.

Antibiotic stewardship education has been provided via the Nebraska Total Care provider website.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Resource: Run Over Run Dashboard

CWP

September Run 3 MY2023 (Prior Year) / September Run 3 MY2024 (Current Year)

Rate by Measure and State

State	Population	Measure	SubMeasure	Prior Num	Prior Den	Prior Rate	Current Num	Current Den	Current Rate	Current %ile Met	Rate Delta	Impact
NE	NE_MCD_EXCL_DUAL	cwp	18to64	1,791	2404	74.50%	1503	1956	76.84%	90th	2.34%	Increase
NE	NE_MCD_EXCL_DUAL	cwp	3to17	5,198	6461	80.45%	5007	6093	82.18%	50th	1.72%	Increase
NE	NE_MCD_EXCL_DUAL	cwp	65plus	9	14	64.29%	5	9	55.56%	75th	-8.73%	Decrease
NE	NE_MCD_EXCL_DUAL	cwp	total	6,998	8879	78.82%	6515	8058	80.85%	75th	2.04%	Increase

Identify any barriers to implementing initiatives:

Difficulty getting access to providers to share quality information, data, and recommendations.

Exacerbated respiratory illness season as indicated by state and public health data July 2022 – July 2023.

Identify strategy for continued improvement or overcoming identified barriers:

Utilized multiple means to disseminate information to providers: quality meetings, eNews, provider townhalls, provider website.

HSAG Assessment:

NTC sufficiently addressed the CY 2023–2024 recommendations regarding the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicator. **NTC**'s performance on this indicator improved from MY 2022 to MY 2023 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

Recommendation **(Effectiveness of Care: Behavioral Health Domain)**

The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure was a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure. The rate for this measure suggests that **NTC** providers were not properly monitoring the status of members with diabetes that used antipsychotics. HSAG recommends that **NTC** review its data production process for these measures to ensure no claims are missing and all available data are being collected for the measures. **NTC** might also consider performance-based incentives for its behavioral health provider network to ensure that all providers are adequately monitoring and supporting high-risk members.

Response

Describe initiatives implemented based on recommendations:

Use of data integration from HIE that evaluates whether labs were completed.

P4P MY2023 and MY2024 include Hemoglobin A1c for diabetic members as a PCP incentive.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Resource: Run Over Run Dashboard

SMD

September Run 3 MY2023 (Prior Year) / September Run 3 MY2024 (Current Year)

State	Population	Measure	SubMeasure	Prior Num	Prior Den	Prior Rate	Current Num	Current Den	Current Rate	Current %ile Met	Rate Delta	Impact
NE	NE_MCD_EXCL_DUAL	smd		81	153	52.94%	83	158	52.53%	No QC Benchmark	-0.41%	Decrease

Identify any barriers to implementing initiatives:

HIE is cost prohibitive for **Nebraska Total Care** to collect additional data on a more frequent basis.

There is a low denominator in the SMD measure to incentivize behavioral health providers.

Identify strategy for continued improvement or overcoming identified barriers:

Nebraska Total Care is asking the state of Nebraska to include diabetic monitoring as part of the quality performance program in MY2025, to drive incentives which may improve testing for members needing diabetic testing, state-wide.

HSAG Assessment:

NTC sufficiently addressed the CY 2023–2024 recommendations regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure. **NTC**'s performance on this measure improved from MY 2022 to MY 2023 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

Recommendation **(Effectiveness of Care: Overuse/Appropriateness Domain)**

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Total* measure indicators were a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark on these measure indicators. The rates for these measure indicators suggest that a diagnosis

of URI resulted in an antibiotic dispensing event for members 3 months to 17 years old. HSAG recommends that **NTC** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommends that **NTC** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.

Response

Describe initiatives implemented based on recommendations:

Ongoing provider education for URI for all priority providers with discussions of technical specifications, coding, and tips to improve, including education on adding any additional diagnosis.

Antibiotic stewardship education has been included on the **Nebraska Total Care** provider website.

Future state: data analysis of URI members within the numerator will identify prescribing trends amongst specific providers. If so, provider outreach and education will be conducted.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Resource: Run Over Run Dashboard
URI
September Run 3 MY2023 (Prior Year) / September Run 3 MY2024 (Current Year)

State	Population	Measure	SubMeasure	Prior Num	Prior Den	Prior Rate	Current Num	Current Den	Current Rate	Current %ile Met	Rate Delta	Impact
NE	NE_MCD_EXCL_DUAL	uri	age1864	688	3392	20.28%	659	3393	19.42%	Less than 5th	-0.86%	Decrease
NE	NE_MCD_EXCL_DUAL	uri	age3mth	1,357	12582	10.79%	1230	11398	10.79%	Less than 5th	0.01%	Increase
NE	NE_MCD_EXCL_DUAL	uri	age65p	7	34	20.59%	5	24	20.83%	Less than 5th	0.25%	Increase
NE	NE_MCD_EXCL_DUAL	uri	total	2,052	16008	12.82%	1894	14815	12.78%	Less than 5th	-0.03%	Decrease

Identify any barriers to implementing initiatives:

Difficulty getting access to providers to share quality information, data, and recommendations.

Exacerbated respiratory illness season as indicated by state and public health data July 2022 – July 2023.

Identify strategy for continued improvement or overcoming identified barriers:

Utilized multiple means to disseminate information to providers: quality meetings, eNews, provider townhalls, provider website.

Post data analysis, targeted messaging identified by trending.

HSAG Assessment:

NTC did not sufficiently address the CY 2023–2024 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator. **NTC**'s performance on this indicator was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes **NTC**'s work with providers on antibiotic stewardship and performance measure reporting, and recommends that **NTC** continue these efforts.

NTC sufficiently addressed the CY 2023–2024 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Total* measure indicator. **NTC**'s MY 2023 performance on this indicator is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

***Recommendation* (Risk Adjusted Utilization Domain)**
The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **NTC**. **NTC** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. HSAG recommends that **NTC** work with its providers to ensure diagnosis and treatment of members are complete and precise to improve readmission rates.
Response
Describe initiatives implemented based on recommendations: Annually, **Nebraska Total Care** offers providers an incentive to complete continuity of care and risk documentation, which includes an annual PCP visit and review of active diagnosis codes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Resource: Quality Data Hub PCR September Run 3 PMY2023 (Previous Year) / September Run 3 PMY2024 (Current Year)

FLOWCHART_RUN_NAME	REPORTING_POPULATION_NAMI	MEASURE_KEY	SUBMEASURE_KE	TOTAL_DENOM	TOTAL_INDEX_STAYS	TOTAL_NUMER	OBSERVED_READMISSIONS	EXPECTED_READMISSIONS	OBSERVED_READMISSIONS_RATI	EXPECTED_READMISSIONS_RATE	OE_RATIO
PMY23_MCD_CE_STD_SEPRUN3_L1	NE_MCD_EXCL_DI	pcrmy22	mcdtot	2313	2313	253	253	246.7328	0.109381755	0.106672201	1.025400757
PMY24_MCD_CE_STD_SEPRUN3_1_L1	NE_MCD_EXCL_DI	pcrmy23	mcdtot	1960	1960	206	206	215.0959092	0.105102041	0.109742811	0.95771231

Identify any barriers to implementing initiatives: Cumbersome and labor-intensive process for providers and staff
Identify strategy for continued improvement or overcoming identified barriers: Additional investigation into health information exchange platforms for a potential to reduce burden on providers and staff.
HSAG Assessment: **NTC** did not sufficiently address the CY 2023–2024 recommendations regarding the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator. **NTC**'s performance on this indicator was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes that **NTC** offers provider incentives to improve performance on this indicator, and recommends that **NTC** continue working with providers in areas that influence measure performance.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table B-13—Compliance With Regulations—Trended Performance for NTC

Standard and Applicable Review Years*	Year One (CY 2022–2023)**	Year Two (CY 2023–2024)**	Year Three (CY 2024–2025)**
Standard Number and Title	**NTC Results**		
Standard I—Enrollment and Disenrollment	100%		
Standard II—Member Rights and Confidentiality		100%	100%
Standard III—Member Information		100%	100%
Standard IV—Emergency and Poststabilization Services	100%		100%
Standard V—Adequate Capacity and Availability of Services		100%	
Standard VI—Coordination and Continuity of Care		100%	100%
Standard VII—Coverage and Authorization of Services		84.2%	100%
Standard VIII—Provider Selection and Program Integrity	94%		
Standard IX—Subcontractual Relationships and Delegation	75%		
Standard X—Practice Guidelines	100%		100%
Standard XI—Health Information Systems	100%		
Standard XII—Quality Assessment and Performance Improvement	100%		
Standard XIII—Grievance and Appeal System		100%	92.0%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Strengths

NTC submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Six out of seven standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

NTC achieved full compliance for the Member Rights and Confidentiality standard, indicating members are receiving timely and adequate access to information that can assist them in accessing care and services. **[Access]**

NTC achieved full compliance for the Member Information standard, indicating members are receiving information regarding their benefits, rights, and protections. **[Access]**

NTC achieved full compliance for the Emergency and Poststabilization Services standard, demonstrating the MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. **[Timeliness and Access]**

NTC achieved full compliance for the Coordination and Continuity of Care standard, demonstrating the MCO had adequate processes in place for its care management program. **[Quality, Timeliness, and Access]**

NTC achieved full compliance for the Coverage and Authorization of Services standard, demonstrating the MCO had an effective system to review, approve, or deny authorization requests while consistently applying the medical necessity criteria. **[Timeliness and Access]**

NTC achieved full compliance for the Practice Guidelines standard, demonstrating the MCO had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. **[Quality]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

NTC should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

For the Member Information standard, HSAG recommended that NTC update the member handbook to improve its clarity and direct members to the grievances department for assistance with the filing process for grievances. Additionally, HSAG recommended that NTC also add the following requirements to the member handbook policy to ensure that the member handbook informs members of the information available to members, upon request, including:

- The MCO's physician incentive plans.
- The MCO's service utilization policies.
- Reports of transactions between the MCO and parties in interest (as defined in 1318[h] of the Public Health Service Act) provided to the State. **[Access]**

For the Emergency and Poststabilization Services standard, HSAG recommended that NTC revise their Emergency and Post Stabilization Services policy and procedure (CC.UM.54) to include the provision

that if the member receives emergency or poststabilization services from a provider outside the MCO's network, the MCO must limit member charges to an amount no greater than what the MCO would charge if he or she had obtained the services through an in-network provider. Following the review, NTC submitted an updated policy that now includes emergency services. The policy will be going through NTC's review and approval process. **[Timeliness and Access]**

For the Coverage and Authorization of Services standard, HSAG recommended that NTC allow providers/hospitals time to submit requested clinical information prior to rendering an ABD. **[Timeliness and Access]**

For the Practice Guidelines standard, HSAG recommended that NTC distinguish practice guidelines from payment policies on its website. The MCO should disseminate to providers, members, and potential members access to the adopted dental practice guidelines, Nebraska-specific guidelines, and any other available practice guidelines. **[Quality]**

NTC received a score of 92 percent for the Grievance and Appeal System standard. As a result, NTC's appeal resolution notices must be in writing and meet the language and format requirements of 42 CFR §438.10. Furthermore, if the MCO denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the time frame for standard resolution.
- Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution.
- Follow up within two calendar days with a written notice of the denial of expedition and inform the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. **[Quality, Timeliness, and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-14 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table B-14—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendation
NTC should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes.
Response
Describe initiatives implemented based on recommendations: Thorough review and analysis of findings and recommendations is conducted to develop performance improvement initiatives. The Compliance team monitors changes to assess effectiveness and ensure required

regulatory and contractual requirements are met. Ongoing support of the Senior Leadership team, weekly, provides an additional layer of reporting for regular updates on progress and impacts of implemented changes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Five out of six standards reviewed met 100% compliance, reflecting an overall improvement in **NTC** results, noting thorough and comprehensive approaches for maintaining compliance with regulatory and contractual requirements.
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: Compliance will continue to monitor key performance indicators that measure effectiveness of regulatory and contractual requirements and will regularly report updates to multidisciplinary stakeholders.
HSAG Assessment: **NTC** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
For the Member Information standard, HSAG recommended that **NTC** make available a provider directory on the website in a machine-readable file and format that is useful to the member.
Response
Describe initiatives implemented based on recommendations: **NTC** currently provides a PDF version of the provider directory that is machine-readable.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: An additional CSV file of the provider directory will be posted to the website to provide an additional option for machine-readable accessibility.
HSAG Assessment: **NTC** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
NTC received a score of 84.2 percent for the Coverage and Authorization of Services standard. **NTC** must revise its policies, procedure, and timeliness monitoring to align with the federal regulation that includes accurate time frames for making expedited authorization decisions and provide notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. Additionally, **NTC** must ensure policies and procedures include all provisions for extending the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the *provider* requests an extension. • The MCE justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

Response
Describe initiatives implemented based on recommendations: **Nebraska Total Care** completed revisions to applicable policies based on HSAG recommendations in which MLTC reviewed and approved those policies. Ongoing monitoring of prior authorization timeliness is reported to leadership regularly and metrics along with policy updates are reviewed during quarterly committees.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Nebraska Total Care** remains compliant with month over month timeliness processing of prior authorizations and conducts reviews of all policies at least annually.
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: Ongoing review of policy and procedure documents will continue to be conducted at least annually. Additional oversight and reporting of performance metrics will be shared through multi-disciplinary teams and committees.
HSAG Assessment: **NTC** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
If the MCE extends the time frame for standard or expedited authorization decisions, it must: • *Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires).* • *Inform the member of the right to file a grievance if he or she disagrees with that decision.* • *Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.*
Response
Describe initiatives implemented based on recommendations: **Nebraska Total Care** completed revisions to applicable policies based on HSAG recommendations in which MLTC reviewed and approved those policies. In addition, **Nebraska Total Care** utilizes MLTC approved member notification templates that inform the member of their right to file a grievance, in the event of a standard or expedited authorization extension.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Nebraska Total Care** remains compliant with month over month timeliness processing of prior authorizations and conducts reviews of all policies at least annually.
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: Ongoing review of policy and procedure documents will continue to be conducted at least annually. Additional oversight and reporting of performance metrics will be shared through multi-disciplinary teams and committees.
HSAG Assessment: **NTC** sufficiently addressed the CY 2023–2024 recommendation.

Recommendation
Furthermore, NTC must revise all applicable letters to clearly state that members may file an appeal orally or in writing. Additionally, NTC must revise its applicable NABD letter templates to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal.
Response
Describe initiatives implemented based on recommendations: Nebraska Total Care completed revisions to all applicable letter templates based on HSAG recommendations in which MLTC reviewed and approved those templates.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All applicable letter templates have been re-formatted during this update process to present standard language.
Identify any barriers to implementing initiatives: N/A
Identify strategy for continued improvement or overcoming identified barriers: N/A
HSAG Assessment: NTC sufficiently addressed the CY 2023–2024 recommendation.

Validation of Network Adequacy

Results

Findings on the Information Systems Capabilities Assessment

HSAG completed an ISCA for NTC and presented the ISCA findings and assessment of any concerns related to data sources used in the NAV to DHHS and NTC.

- HSAG evaluated the information systems data processing procedures and personnel that NTC had in place to support network adequacy indicator reporting. HSAG identified no concerns with NTC's information systems data processing procedures and personnel.
- HSAG evaluated the information systems and processes used by NTC to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG identified no concerns with NTC's enrollment data capture, data processing, data integration, data storage, or data reporting.
- HSAG evaluated the information systems and processes used by NTC to capture provider data as well as NTC's provider data system(s), and did not identify concerns with provider data capture, data processing, data integration, data storage, or data reporting.
- HSAG did not identify any concerns related to the quality or completeness of data provided by delegated entities. HSAG identified no concerns with NTC's network adequacy methods or indicator reporting processes.

Overall, HSAG determined that **NTC**'s data collection procedures, network adequacy methods, and network adequacy results were acceptable.

Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **NTC** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table B-15 summarizes HSAG's validation ratings for **NTC** by indicator type, with **NTC** receiving *High Confidence* for all access and availability and time and distance indicators.

Table B-15—Summary of NTC's Validation Findings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time and Distance (n = 43)	100%	0%	0%	0%
Access and Availability (n = 17)	100%	0%	0%	0%

N = the number of indicators of that type.

Time and Distance standards

DHHS has set geographic access standards that require a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier). As mentioned previously, the exception is for access to hospitals, for which the standard is defined in terms of a maximum travel time (30 minutes) from the member's residence.

Table B-16 displays the percentage of each **NTC**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table B-16–Percentage of NTC Members with Required Access to Care by Provider Type and Urbanicity

Provider Category	Percentage of Members With Required Access*
PCP, Urban	100.0%
PCP, Rural	100.0%
PCP, Frontier	100.0%
High-Volume Specialists**	
Cardiology	>99.9%
Neurology	100.0%
OB/GYN	>99.9%

Provider Category	Percentage of Members With Required Access*
Oncology-Hematology	100.0%
Orthopedics	100.0%
Pharmacy, Urban***	95.9%
Pharmacy, Rural***	92.6%
Pharmacy, Frontier***	97.7%
All Behavioral Health Inpatient and Residential Service Providers, Urban	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Rural	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Frontier	100.0%
All Behavioral Health Outpatient Assessment and Treatment Providers, Urban	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Rural	99.8%
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	97.6%
Hospitals	88.3%
Optometry, Urban	>99.9%
Optometry, Rural	>99.9%
Optometry, Frontier	100.0%
Ophthalmology, Urban	97.9%
Ophthalmology, Rural	100.0%
Ophthalmology, Frontier	100.0%
Dental	
Dentist, Urban	100.0%
Dentist, Rural	99.9%
Dentist, Frontier	100.0%
Dental Specialists	
Oral Surgeon, Urban	91.3%
Oral Surgeon, Rural	70.8%
Oral Surgeon, Frontier	26.1%
Orthodontist, Urban	84.4%
Orthodontist, Rural	67.3%
Orthodontist, Frontier	100.0%
Periodontist, Urban	97.8%
Periodontist, Rural	78.7%
Periodontist, Frontier	85.8%
Pediadontist, Urban	—
Pediadontist, Rural	—

Provider Category	Percentage of Members With Required Access*
Pediadontist, Frontier	—

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity.
"—" indicates the MCO did not submit data for this provider type.
*The minimum access is required for 100 percent of members unless otherwise noted.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.
***For pharmacies, the standard must be met for 90 percent of members within urban counties, or 70 percent of members in rural and frontier counties.

Table B-17 display the percentage of **NTC**'s members with the access to care required by contract standards for behavioral health categories by Behavioral Health Region.

Table B-17–Percentage of NTC Members with Required Access to Inpatient and Residential Service Providers by Behavioral Health Region

Provider Category	Percentage of Members With Required Access*
All Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%
All Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	98.4%
Region 3	100.0%
Region 4	99.8%
Region 5	100.0%
Region 6	100.0%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.
*The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table B-18 identifies the counties where the minimum geographic access standards were not met by NTC in a specific urbanicity or Behavioral Health Region for each applicable provider category, including pediatric specialists for appropriate categories. Results are presented separately for the general and pediatric populations as applicable.

Table B-18–Counties Not Meeting Geographic Access Standard by Provider Category for NTC

Provider Category	Counties Not Meeting Standard*
High-Volume Specialists†**	
Cardiology	Cherry
OB/GYN	Cherry
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Madison, Scotts Bluff
Rural	Cherry, Clay, Custer
Frontier	Hooker, Thomas
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Dundy, Grant, Hooker, Thomas
Region 2	Dundy, Grant, Hooker, Lincoln, Thomas
Region 4	Cherry
Hospitals**	
Hospitals	Antelope, Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dawson, Dixon, Dodge, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lancaster, Lincoln, Logan, Loup, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Perkins, Phelps, Pierce, Polk, Red Willow, Richardson, Rock, Saline, Saunders, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Wheeler, York
Optometry	
Urban	Lincoln
Rural	Cherry
Ophthalmology	
Urban	Buffalo, Dawson, Lincoln

Provider Category	Counties Not Meeting Standard*
Dental	
Dentist, Rural	Cherry
Dental Specialists	
Oral Surgeon, Urban	Buffalo, Dawson, Gage, Lincoln, Platte, Scotts Bluff
Oral Surgeon, Rural	Box Butte, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nemaha, Pawnee, Phelps, Red Willow, Richardson, Thayer, Valley
Oral Surgeon, Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas
Orthodontist, Urban	Adams, Buffalo, Dakota, Gage, Hall, Madison, Platte
Orthodontist, Rural	Antelope, Boone, Cedar, Cherry, Clay, Dixon, Fillmore, Hamilton, Harlan, Holt, Jefferson, Kearney, Knox, Merrick, Nance, Nuckolls, Pawnee, Pierce, Polk, Richardson, Stanton, Thayer, Wayne, Webster, York
Periodontist, Urban	Dakota, Dawson, Gage, Lincoln, Platte
Periodontist, Rural	Box Butte, Cherry, Cheyenne, Custer, Dawes, Dixon, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Pawnee, Red Willow, Richardson, Thayer, Valley
Periodontist, Frontier	Boyd, Brown, Dundy, Keya Paha, Rock, Sheridan

*Rows are only shown if at least one county did not meet the standard.
**The standard for this provider category does not differ by urbanicity.
†High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

Network Capacity Analysis

Table B-19 displays the statewide network capacity analysis results for **NTC** (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards. Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table B-19—NTC Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	4,505	1:26
High-Volume Specialists**		
Cardiology	339	1:344
Neurology	331	1:352

Provider Category	Providers	Ratio*
OB/GYN	336	1:123
Oncology-Hematology	147	1:792
Orthopedics	360	1:324
Pharmacy	501	1:233
All Behavioral Health Inpatient and Residential Service Providers	28	1:4,156
All Behavioral Health Outpatient Assessment and Treatment Providers	1,410	1:83
Hospitals	44	1:2,645
Optometry	287	1:406
Ophthalmology	134	1:869
Dental		
Dentist	339	1:344
Dental Specialists		
Oral Surgeon	20	1:5,818
Orthodontist	15	1:7,757
Periodontist	50	1:2,327
Pediadontist	0	—

Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
"—" indicates the MCO did not submit data for this provider type.
* In calculating the ratios, all covered members were considered, except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older, and Pediadontists, where the member population was limited to members 18 years of age and under.
** High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

As an additional point of information in evaluating adequacy of provider networks, the average time and distance to the nearest two providers were calculated across members enrolled in each MCO and for each provider category. Although this analysis included all provider categories, it did not consider urbanicity. Table B-20 displays the statewide average travel times (in minutes) and travel distances (in miles) to the first- and second-nearest providers for **NTC** members.

Table B-20—NTC Members' Average Time and Distance to the Nearest First and Second Provider

Provider Category	First Nearest*	Second Nearest*
	Time (Min.) Dist. (Mi.)	Time (Min.) Dist. (Mi.)
PCP	1.8 / 1.5	2.0 / 1.6
High-Volume Specialists**		
Cardiology	6.9 / 5.8	8.2 / 7.0

Provider Category	First Nearest*	Second Nearest*
	Time (Min.) Dist. (Mi.)	Time (Min.) Dist. (Mi.)
Neurology	9.0 / 7.7	11.9 / 10.3
OB/GYN	7.0 / 6.1	9.2 / 8.1
Oncology-Hematology	9.0 / 7.7	11.0 / 9.5
Orthopedics	5.3 / 4.4	5.9 / 5.0
Pharmacy	2.8 / 2.4	4.9 / 4.2
All Behavioral Health Inpatient and Residential Service Providers	26.9 / 23.7	34.2 / 30.4
All Behavioral Health Outpatient Assessment and Treatment Providers	3.6 / 3.2	4.2 / 3.7
Hospitals	11.2 / 9.6	17.8 / 15.2
Optometry	4.3 / 3.6	4.8 / 4.1
Ophthalmology	7.8 / 6.7	9.0 / 7.7
Dental		
Dentist	5.1 / 4.3	7.2 / 6.3
Dental Specialists		
Oral Surgeon	38.0 / 33.9	42.3 / 37.8
Orthodontist	25.5 / 21.3	38.3 / 31.7
Periodontist	17.3 / 14.9	22.0 / 19.0
Pediadontist	—	—

"—" indicates the MCO did not submit data for this provider type.
*For some members, the nearest in-network providers may be out of state.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

Recommendations Over the Past Year Based on Information Gathered During the Validation Process

Because this year's NAV activity methodology added a new scope of work in alignment with the 2023 release of the CMS EQR Protocol 4, the NAV audit activity was conducted for the first time in CY 2024–2025. HSAG has provided recommendations to **NTC** in the *Summary Assessment of Opportunities for Improvement and Recommendations* section, as necessary, based on the findings from the CY 2024–2025 NAV audit.

Strengths

NTC had processes to ensure the accuracy and completeness of member data through daily error reports, member count checks, quality reports, and system to system (S2S) reports to ensure consistency of data within its Unified Member View (UMV) and across systems. **[Access]**

NTC had processes to maintain provider data, including self-service tools available to providers as needed to support accurate and up-to-date provider information, and vendors to assist in validating provider data accuracy. **[Access]**

NTC had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has *High Confidence* in NTC's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts. **[Access]**

NTC met the State's time and distance standards for 22 of 39 provider category/urbanicity combinations. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

NTC's provider file submitted to HSAG for NAV did not match the provider data it used to perform its network adequacy analysis for submission to DHHS, lacking any pediadontists and including questionable data for periodontists. HSAG recommended that NTC should investigate how its dental specialist data are categorized to ensure that specialists are properly captured in NTC's data, and that the data can be readily and accurately provided to DHHS and the EQRO when requested.

NTC did not meet the time and distance standards for 17 of 39 provider category/urbanicity combinations, although by less than 3 percentage points for nine of these. Aside from the minimal shortfalls of 1 to 3 percentage points that might be expected as a result of routine fluctuations of providers, NTC had more serious gaps in member access to hospitals and all dental specialists. HSAG recommended that NTC maintain current levels of access to care and continue to address network gaps for the following provider categories: Hospitals and Dental Specialists. A list of the specific counties where NTC did not meet standards is provided in Table B-18.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table B-21 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table B-21—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendation
None of NTC's members had access to pediatric outpatient behavioral health specialists within the standard in Regions 1, 2, or 3, and only 45.5 percent of members had access in Region 4 and 84.0 percent in Region 5. Only members residing in Region 6 had access that approached the state standard for these providers (99.1 percent). For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, as contrasted with the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.

Response
Describe initiatives implemented based on recommendations: **Nebraska Total Care** continues to utilize the state provider file and Quest Analytics to engage in conversations with state-based associations such as Nebraska Association of Behavioral Health Organizations (NABHO), Nebraska Hospital Association (NHA), and Nebraska Medical Association, that discuss the need for expansion of access to behavioral health specialists, specifically in rural and frontier areas. As many BH Specialists serve a wide range of ages, given the lower population of members and providers in many rural and frontier areas, we additionally promote telehealth services when allowed by the state, based on service type and service level.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): When reviewing state file for those who match this provider type, with NMC Provider specialty of 26, 62, or 83 and NMC Provider Type of 1, 2, 10, 12, 13, 22, 26, 29, 30, 31, 34, 35, 36, 37, 38, 39, 44, 47, 48, 51, 52, 53, 54, 55, 57, 58, 64, 67, 77, 78, 79, 80, 81, 83, 84, 85, 86, or 87, we have secured agreements with and enrolled 15,747 of 16,189, equal to 97.27% of the available providers on the state file with a Nebraska service location. Variations noted across the Regions include: Region 1 at 95.89%, Region 2 at 96.67%, Region 3 at 96.05%, Region 4 at 98.28%, Region 5 at 94.61%, and Region 6 at 98.51%.
Identify any barriers to implementing initiatives: As an MCO following state provided guidance, **Nebraska Total Care** is unable to enroll School employed providers, who are also present on the state file. For example, the state file identified eight providers in Thayer County as meeting the above outlined criteria; however, due to all eight providers being school employees, they are not within **NTC**'s network. Those eight providers in Thayer County account for 47.06% of the enrolled BH providers.
Identify strategy for continued improvement or overcoming identified barriers: **Nebraska Total Care** currently captures a strong network based on those providers currently enrolled with the state and will continue to work with various provider groups, associations, and other stakeholders, to identify ways that enhance access in rural and frontier counties.
HSAG Assessment: HSAG did not perform a separate analysis of pediatric behavioral health providers this year and notes that **NTC**'s performance across all regions was close to or at the required 100 percent of members with access to providers. HSAG acknowledges **NTC**'s efforts to improve access to pediatric behavioral health providers in its network.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*

UHCCP submitted the clinical PIP, *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions* measure, for the CY 2024–2025 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. HSAG assigned a *High Confidence* level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the third remeasurement. Table C-1 summarizes **UHCCP**'s PIP validation scores.

Table C-1—2024–2025 PIP Validation Results for UHCCP

		Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
PIP Topic	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*Not Applicable*			*Not Applicable*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

Overall, 100 percent of all applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP received a score of *Met*. Table C-2 presents baseline, Remeasurement 1, Remeasurement 2, and Remeasurement 3 performance indicator data for **UHCCP**'s *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

Table C-2—Performance Indicator Results for UHCCP's *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Remeasurement 3 (01/01/2023 to 12/31/2023)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 133 D: 1,131	11.76%	N: 149 D: 1,427	10.44%	N: 180 D: 2,215	8.13%	N: 233 D: 2,531	9.21%	*Yes*

N–Numerator D–Denominator

For the baseline measurement period, **UHCCP** reported that 11.76 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. For the first remeasurement period, **UHCCP** reported that 10.44 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The decrease in the total observed readmission rate of 1.32 percentage points represented an improvement in indicator performance from baseline to Remeasurement 1; however, the improvement was not statistically significant ($p = 0.2905$).

For the second remeasurement period, **UHCCP** reported that 8.13 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 2 rate was an improvement (decrease) of 3.63 percentage points from the baseline rate. The decrease in readmission rates from baseline to Remeasurement 2 represented a statistically significant improvement ($p = 0.0006$) in indicator performance compared to initial indicator results.

For the third remeasurement period, **UHCCP** reported that 9.21 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The Remeasurement 3 rate was an improvement (decrease) of 2.55 percentage points from the baseline rate. The decrease in readmission rates from baseline to Remeasurement 3 represented a statistically significant improvement ($p = 0.0173$) in indicator performance compared to baseline results.

Nonclinical PIP: *Improving the Member Experience with the Health Plan's Member Services*

UHCCP submitted the nonclinical PIP, *Improving the Member Experience with the Health Plan's Member Services*, focused on improving performance in the percentage of adult members who responded to Question 24 in the CAHPS Health Plan Survey 5.1H "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" with a response of "Usually" or "Always," for the CY 2024–2025 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level that the PIP achieved significant improvement. HSAG assigned a *Moderate Confidence* level for Validation Rating 2 because the performance indicator results demonstrated improvement over baseline results at the first remeasurement, but the improvement was not statistically significant. Table C-3 summarizes **UHCCP**'s PIP validation scores.

Table C-3—2024-2025 PIP Validation Results for UHCCP

		Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
PIP Topic	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving the Member Experience with the Health Plan's Member Services	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

Overall, 100 percent of all applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP received a score of *Met*. Table C-4 presents baseline and Remeasurement 1 performance indicator data for **UHCCP**'s *Improving the Member Experience with the Health Plan's Member Services* PIP, which was used to objectively assess for improvement.

Table C-4—Performance Indicator Results for UHCCP's *Improving the Member Experience with the Health Plan's Member Services* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
The percentage of adult members who responded to Question 24 in the CAHPS Health Plan Survey 5.1H "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" with a response of "Usually" or "Always."	N: 60 D: 76	78.95%	N: 51 D: 64	79.69%	*Not Assessed*

N–Numerator D–Denominator

For the baseline measurement period, **UHCCP** reported that 78.9 percent of adult members who responded to CAHPS Survey Question 24 reported that the health plan's customer service "usually" or "always" provided needed information or help in the last six months. For the first remeasurement period, **UHCCP** reported that 79.69 percent of adult members who responded to CAHPS Survey Question 24 reported that the health plan's customer service "usually" or "always" provided needed information or help in the last six months. The percentage of adult members who responded to CAHPS Survey Question 24 with a response of "usually" or "always" increased by 0.74 percentage point which represented an improvement from baseline to Remeasurement 1; however, the improvement was not statistically significant ($p = 0.9143$).

Interventions

Clinical PIP: *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*

For the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP, **UHCCP** reported using data analyses, intervention evaluation results, and workgroup discussion to identify the following barriers and interventions to improve performance indicator outcomes.

Table C-5 displays the barriers and interventions as documented by **UHCCP** for the PIP.

Table C-5—Barriers and Interventions for the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP

Barriers	Interventions
Member medication noncompliance.	Targeted outreach by care management staff to reconcile medications within 14 days of an acute inpatient discharge for members with a primary behavioral health or medical diagnosis.
Lack of member participation in care management services to support management of behavioral health and/or physical medical conditions.	Targeted outreach by care management staff for members with a primary behavioral health or medical diagnosis prior to an acute inpatient stay to provide education on care management services and engage members in care management services.

Barriers	Interventions
Insufficient or inaccurate member contact information.	Actively seek out and update member contact information as part of targeted member outreach.

Nonclinical PIP: *Improving the Member Experience with the Health Plan's Member Services*

For the *Improving the Member Experience with the Health Plan's Member Services* PIP, **UHCCP** reported using data analyses, intervention evaluation results, and workgroup discussion to identify the following barriers and interventions to improve performance indicator outcomes.

Table C-6 displays the barriers and interventions as documented by **UHCCP** for the PIP.

Table C-6—Barriers and Interventions for the *Improving the Member Experience with the Health Plan's Member Services* PIP

Barriers	Interventions
• Member experience survey is voluntary for members; therefore, not all members respond. • Lack of member participation in the survey.	Members are provided a convenient opportunity to complete the survey by opting in to take a three-question United Experience Survey (UES) following their inbound call to Member Services to rate their experience.
A lower number of completed surveys provides supervisors with fewer opportunities to provide feedback and coach staff.	Team supervisors review inbound member calls to Member Services and provide feedback and coaching to staff for calls receiving a composite score of less than or equal to 92 percent on the UES.
The survey is voluntary, and the goal is to complete 10 surveys each business day; however, there is no guarantee how many member outreach calls will be needed to complete 10 surveys.	Designated health plan staff randomly select and contact 10 members who completed an inbound customer service call per day to conduct follow-up satisfaction surveys.

Strengths

Based on the PIP validation findings, HSAG identified the following strengths:

- **UHCCP** followed a methodologically sound PIP design for the clinical and nonclinical PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **UHCCP** reported accurate indicator results and appropriate data analyses and interpretations of results for the clinical and nonclinical PIPs. **[Quality]**
- **UHCCP** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**
- **UHCCP** reported Remeasurement 3 results for the *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP that demonstrated statistically significant and sustained improvement in the readmissions rate compared to baseline performance. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

Based on the PIP validation findings, HSAG did not identify any opportunities for improvement.

To support sustained improvement in the access to and timeliness of dental care for its members, HSAG offered the following recommendations for **UHCCP**:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses. **[Quality]**
- Use PDSA cycles or other methodologically sound processes to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality]**

Follow-Up on Prior Year's Recommendations (Requirement §438.364[a][6])

Table C-7 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table C-7—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendation
Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
Response
Describe initiatives implemented based on recommendations: A review of the casual/barrier analyses was completed annually for both the PCR PIP and the Member Experience PIP. The PIP work group identified and reviewed barriers and opportunities for improvement. PCR PIP: The PIP outreach staff were retrained on the interventions and related documentation at monthly PIP staff meetings in January 2023, February 2023, March 2023, April 2023, September 2023, and November 2023. This training included documentation and completion of the Transition of Care Assessment, medication reconciliation, and appropriately recording member contact information in the member charting system. Ongoing retraining with PIP staff occurred as needed and as appropriate. PIP staff assisted the member with any identified barriers, such as social determinants of health (SDOH) and made referrals for ongoing case or care management as needed. All member call scripts were reviewed on an ongoing basis and updated when needed.

Member Experience PIP: Designated staff were provided training related to the new intervention prior to its start date of August 1, 2023. Retraining and teaching was provided when staff had questions. The call script was reviewed on an ongoing basis and updated when needed.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PCR PIP: The Healthcare Effectiveness Data and Information Set® (HEDIS) Plan All-Cause Readmission (PCR) rate changed from a Baseline Year (MY2019) rate of 11.76% to Remeasurement Year 1 (MY2021) rate of 10.44%. The HEDIS PCR rate continued to trend downward in Remeasurement Year 2 (MY2022) to 8.13%, which showed a statistically significant improvement. In Remeasurement Year 3 (MY2023), the HEDIS PCR rate slightly increased to 9.21%. Despite the slight increase, this also showed a statistically significant improvement from baseline.

Member Experience PIP: The percentage of eligible members who provided a response of "Usually" or "Always" to Question Number 24 in the CAHPS® Health Plan Survey, Adult Version, was 78.9% for Baseline Year (MY2022). This percentage improved from the Baseline Year (MY2022) to Remeasurement Year 1 (MY2023) to a rate of 79.7%.

Identify any barriers to implementing initiatives:

PCR PIP: Ongoing quarterly analysis showed stronger efforts were needed to successfully reach members who did not have a valid phone number within 30 days of discharge. However, lack of accurate or up to date contact information continued to be a barrier in reaching these members. Successful inpatient outreaches also continued to be a barrier in reaching members due to medical testing, routine inpatient care, and inpatient behavioral health units and facilities limiting or prohibiting inpatient member interaction.

Member Experience PIP: Ongoing quarterly analysis demonstrated that members may not want to complete the survey following up on their recent call to Member Services as the survey was voluntary. This led to no guarantee on how many member outreach calls would be needed to complete ten successful surveys each business day.

Identify strategy for continued improvement or overcoming identified barriers:

PCR PIP: The Health Plan continued with the three identified interventions through 2023 as directed by Health Services Advisory Group (HSAG). PIP outreach staff continued to access every platform and electronic health record available to them, including those with live data, to find a valid phone number. PIP outreach staff also outreached members' pharmacies or doctor's offices and sent emails and letters to members attempting to find a valid phone number or to reach the member. PIP outreach staff also continued to attempt to engage with facility discharge planners to identify and address any member barriers prior to discharge.

Member Experience PIP: The Health Plan continued with the identified intervention through 2023 as directed by HSAG. Staff continued to outreach members to complete the survey following up on their recent call to Member Services each business day in their strongest effort to complete ten successful surveys.

HSAG Assessment:

UHCCP sufficiently addressed the CY 2023–2024 recommendation.

Recommendation

Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.

Response
Describe initiatives implemented based on recommendations: PCR PIP: The Health Plan utilized a Key Driver Diagram and Failure Modes and Effects Analysis (FMEA) to determine and prioritize barriers and process gaps or weaknesses. PIP outreach staff were retrained on the interventions and related documentation techniques in January 2023, February 2023, March 2023, April 2023, September 2023, and November 2023. As necessary in 2023, staff were retrained on the appropriateness of completing the Transition of Care assessment, medication reconciliation, and documenting accurate and up to date member contact information in the member charting system. PIP outreach staff were also educated regarding assisting the member with any identified barriers, such as SDOH, and making referrals for ongoing care and case management as needed. Continued retraining and re-education of staff occurred as appropriate. All Standard Operating Procedures (SOPs) were kept up to date to include applicable documentation requirements and call scripts for each intervention. Member Experience PIP: The Health Plan used a Key Driver Diagram to determine and prioritize barriers and process any gaps or weaknesses. Staff were provided training when the new intervention started on August 1, 2023, regarding making their strongest effort to complete ten successful surveys following up on member's recent call to Member Services each business day.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PCR PIP: A review of documentation on a weekly basis supported that retraining of PIP outreach staff and member call scripts was successful. Member Experience PIP: A daily review of documentation showed that training of staff was successful. Referrals were sent to case management as needed.
Identify any barriers to implementing initiatives: PCR PIP: An increased volume of admissions and discharges led to decreased bandwidth for staff to outreach for each identified intervention at times. Member Experience PIP: Periodically there were days when fewer eligible members called Member Services, making it more difficult to complete ten successful surveys. Sometimes, it was more difficult to successfully reach members or encourage members to take the survey, making it challenging to complete ten successful surveys.
Identify strategy for continued improvement or overcoming identified barriers: PCR PIP: An ongoing review of documentation was completed weekly on a random selection of records for each PIP outreach staff member. Documentation was held to the SOP, which outlined the process the staff had previously been trained on. Staff retraining was held at monthly meetings if needed, or sooner if necessary. Due to the increased volume of admissions and discharges, the priority was made to address discharge outreaches first. Member Experience PIP: A daily review of completed surveys from the previous business day was done to ensure completion. Staff continued to complete ten successful surveys each business day to follow up on members' recent calls to Member Services, except for when individuals were unable to be reached after multiple attempts by staff or there were not ten individuals to survey on a given day.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.

Recommendation
Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The MCE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.
Response
Describe initiatives implemented based on recommendations: PCR PIP: The Health Plan completed quarterly and annual evaluations of data, as well as a PDSA cycle, to measure the effectiveness of each intervention. The PIP team completed targeted outreaches to members in the following three interventions: 1. Care management to outreach members with a primary behavioral health or medical diagnosis after an acute inpatient stay to reconcile medications within 14 calendar days of discharge. 2. Care management to outreach members with a primary behavioral health or medical diagnosis prior to discharge from an acute inpatient stay to educate and engage the member in care management services. 3. Care management to outreach members with a primary behavioral health or medical diagnosis after an acute inpatient stay within 30 days of discharge and attempt to locate a valid phone number to successfully reach member and update the member's contact information. Member Experience PIP: The Health Plan completed quarterly and annual evaluations of the data to measure the effectiveness of each intervention. Designated Health Plan staff outreached members for the following intervention: Designated Health Plan staff will complete ten, two (2) question surveys each business day following up on successful inbound member phone calls received by Member Services. Members will be randomly selected.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PCR PIP: The Health Plan continued with interventions one through three. In 2023, intervention number one demonstrated 2,328 unique members were successfully outreached and completed medication reconciliation and a Transition of Care assessment within 14 calendar days of discharge. This was an increase from MY2022's unique members successfully outreached of 2,290. Intervention number two showed that 252 members were successfully outreached prior to discharge from an acute inpatient stay for education regarding the available care management benefit. This was a decrease from MY2022's unique members successfully outreached prior to discharge of 363. Intervention number three demonstrated that 32 unique members were successfully outreached post-discharge that had previously been unable to reach due to invalid contact information. This was a decrease from MY2022's unique members successfully outreached post-discharge that had previously been unable to reach due to valid contact information of 132. Member Experience PIP: Due to a new intervention starting on August 1, 2023, there was only data available for Quarters 3 and 4 of 2023. In 2023, 1,042 members were outreached to successfully complete the survey to follow up on their recent Member Services call. Of these 1,042 members, 896 members confirmed they were able to get the assistance needed when calling Member Services. Of the members successfully outreached, 146 members stated their needs were not met and were outreached by Health Plan staff, if they were agreeable, to follow up on the issue and offer to enroll in care management services.
Identify any barriers to implementing initiatives: PCR PIP: The below ongoing barriers were identified: a. Difficulty in obtaining and maintaining valid contact information for members.

b. Inpatient telephonic outreaches were difficult, as members may be unavailable due to medical testing or other medical services such as Physical Therapy, Speech Therapy, or Occupational Therapy.
c. Inpatient behavioral health units or facilities limiting or prohibiting member phone interactions.

Member Experience PIP: The below ongoing barriers were identified:

a. Some days, there were fewer eligible members who had called Member Services for assistance, making it more difficult to complete ten successful surveys.

Sometimes, it was more difficult to successfully reach members or encourage members to take the survey, making it challenging to complete ten successful surveys.

Identify strategy for continued improvement or overcoming identified barriers:
PCR PIP: The Health Plan PIP work group completed a Plan Do Study Act (PDSA) cycle and a Failure Modes and Effects Analysis (FMEA) to re-evaluate the effectiveness of the identified interactions.

Member Experience PIP: A daily review of completed surveys from the previous business day was done to ensure completion. Staff continued to complete ten successful surveys each business day to follow up on members' recent calls to Member Services, except for when individuals were unable to be reached after multiple attempts by staff or there were not ten individuals to survey on a given day.

HSAG Assessment:
UHCCP sufficiently addressed the CY 2023–2024 recommendations.

Recommendation

Identify strategies to continue and spread successful interventions to support sustained and further improvement in performance indicator outcomes over time.

Response

Describe initiatives implemented based on recommendations:
PCR PIP: Integrated Health and Social Services (IHSS) staff have continued to outreach members post-discharge to complete a Transition of Care assessment, medication reconciliation, and enroll in case or care management services if applicable. Staff also assist members with any identified barriers, such as SDOH.

Member Experience PIP: IHSS staff continue to work with members to outreach Member Services with any identified questions or concerns.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PCR PIP: Since the PIP and interventions ended on December 31, 2023, the unaudited PCR HEDIS® rate as of September 20, 2024, is 10.01%. IHSS staff will continue to outreach members post-discharge to find valid contact information and complete a Transition of Care assessment, medication reconciliation, and enroll in case or care management services if applicable.

Member Experience PIP: The Health Plan will continue to monitor all CAHPS® results for 2024 when they are available in 2025, including question number 24 from the Adult CAHPS® survey ("In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"), which is part of the "Rating of Health Plan" composite.

Identify any barriers to implementing initiatives:
PCR PIP: Lack of current or up to date contact information remains a barrier for IHSS staff outreaching these members.

Member Experience PIP: The Health Plan will continue to monitor all CAHPS® results for 2024 when they are available in 2025, including question number 24 from the Adult CAHPS® survey ("In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"), which is part of the "Rating of the Health Plan" composite.
Identify strategy for continued improvement or overcoming identified barriers: PCR PIP: IHSS staff will continue accessing every platform and electronic health record available to them, including those with live data, to find a valid phone number. IHSS staff will also outreach members' pharmacies or doctor's offices and send emails and letters to the member attempting to find a valid phone number or to reach the member. Member Experience PIP: The Health Plan will continue to monitor all CAHPS® results for 2024 when they are available in 2025, including question number 24 from the Adult CAHPS® survey ("In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"), which is part of the "Rating of the Health Plan" composite.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.

Validation of Performance Measures

Results for Information Systems Standards Review

Table C-8 provides a summary of **UHCCP**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in *Appendix D* of this report.

Table C-8—Summary of Compliance With IS Standards for UHCCP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software.	**UHCCP** was compliant with IS Standard R for data management and reporting. The LO determined that **UHCCP** had procedures in place so that all data elements required for HEDIS reporting were adequately captured. The LO determined that **UHCCP** had policies and procedures in place for validation of data extraction, transformation, and integration. The LO determined that **UHCCP** was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	**UHCCP** was compliant with IS Standard C for clinical and care delivery data. The LO determined that **UHCCP** had policies and procedures in place for submitted data that conform with industry standards. Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off). • IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed.	**UHCCP** was compliant with IS Standard M for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2023 FARs Review
• IS M3—Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. • IS M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	**UHCCP** was compliant with IS Standard A for administrative data. The LO determined that the MCO appropriately validated that data conform with industry standards and measure requirements. The LO reviewed the membership information system to ensure that it appropriately enables measurement. Sufficient validation processes were in place to ensure that data are accurate and complete.

Results for Performance Measures

Table C-9 and Table C-10 present the audited rates in the IDSS as submitted by **UHCCP**. According to the DHHS' required data collection methodology, the rates displayed in Table C-9 reflect all final reported rates in **UHCCP**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **UHCCP** may have received an "*NA*" status for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table C-9—HEDIS Audit Results for UHCCP

Audit Finding	Description	Audit Result
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	***R***
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	***NA****
The MCO did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	***NB****

Audit Finding	Description	Audit Result
The MCO chose not to report the measure.	Not Reported	***NR***
The MCO was not required to report the measure.	Not Required	***NQ****
The rate calculated by the MCO was materially biased.	Biased Rate	***BR***
The MCO chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).	Unaudited	***UN***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).

**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table C-10—UHCCP's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Effectiveness of Care Domain: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Body Mass Index (BMI) Percentile Documentation—Total	71.53%	68.37% ★	70.56% ★	R
Counseling for Nutrition—Total	66.42%	66.67% ★★	55.96% ★	R
Counseling for Physical Activity—Total	65.94%	66.91% ★★	52.07% ★	R
Childhood Immunization Status (CIS)				
Combination 3	72.51%	77.37% ★★★★★	74.45% ★★★★★	R
Combination 7	63.99%	69.10% ★★★★★	66.42% ★★★★★	R
Combination 10	49.39%	53.77% ★★★★★	48.18% ★★★★★	R
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	34.55%	82.00% ★★★	81.02% ★★★	R
Combination 2 (Meningococcal, Tdap, HPV)	34.55%	37.47% ★★★	35.52% ★★★	R
Lead Screening in Children (LSC)				
Lead Screening in Children	70.32%	73.48% ★★★★	70.80% ★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	57.42%	60.58% ★★★	54.99% ★★	R
Chlamydia Screening in Women (CHL)				
Ages 16 to 20 Years	28.35%	27.04% ★	26.77% ★	R
Ages 21 to 24 Years	39.71%	38.59% ★	38.53% ★	R
Total	32.69%	31.90% ★	31.84% ★	R
Colorectal Cancer Screening (COL)				
Ages 46 to 50 Years	—	27.24% NC	35.95% ★★★★★	R
Ages 51 to 75 Years	—	51.73% NC	53.38% ★★★★	R
Total	—	47.51% NC	49.59% ★★★★★	R
Effectiveness of Care Domain: Respiratory Conditions				
Appropriate Testing for Pharyngitis (CWP)				
Ages 3 to 17 Years	71.20%	69.34% ★	80.98% ★★	R
Ages 18 to 64 Years	60.64%	63.66% ★★	75.70% ★★★	R
Ages 65 Years and Older	NA	NA	NA	R
Total	68.10%	67.52% ★★	79.54% ★★	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.83%	28.57% ★★★★	28.67% ★★★★	R
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	73.35%	72.62% ★★★	78.10% ★★★★	R
Bronchodilator	86.53%	86.43% ★★★	85.16% ★★★	R
Asthma Medication Ratio (AMR)				
Ages 5 to 11 Years	78.21%	74.43% ★★	76.03% ★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Ages 12 to 18 Years	71.43%	74.95% ★★★★	75.83% ★★★★	R
Ages 19 to 50 Years	70.88%	68.01% ★★★★	69.87% ★★★★	R
Ages 51 to 64 Years	64.79%	64.32% ★★★	69.42% ★★★	R
Total	72.59%	70.97% ★★★★	72.75% ★★★★	R
Effectiveness of Care Domain: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	71.53%	76.40% ★★★★★	72.51% ★★★★	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
Persistence of Beta-Blocker Treatment After a Heart Attack	80.70%	76.92% ★★	NA	R
Effectiveness of Care Domain: Diabetes				
Hemoglobin A1c Control for Patients with Diabetes (HBD)				
HbA1c Control (<8.0%)	60.10%	60.10% ★★★★	63.02% ★★★★	R
*HbA1c Poor Control (>9.0%)**	31.14%	29.44% ★★★★★	29.44% ★★★★	R
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure <140/ 90 mm Hg	76.89%	76.16% ★★★★★	79.56% ★★★★★	R
Eye Exam for Patients With Diabetes (EED)				
Eye Exam	65.94%	65.69% ★★★★★	65.94% ★★★★★	R
Effectiveness of Care Domain: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	66.16%	64.46% ★★★	65.90% ★★★	R
Effective Continuation Phase Treatment	52.98%	47.48% ★★★	47.79% ★★★	R
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	39.15%	48.05% ★★★	44.02% ★★	R
Continuation and Maintenance Phase	47.85%	55.04% ★★★	48.20% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Ages 6 to 17 Years	57.83%	53.06% ★★★	54.46% ★★★	R
30-Day Follow-Up—Ages 6 to 17 Years	80.58%	76.12% ★★★★	77.57% ★★★	R
7-Day Follow-Up—Ages 18 to 64 Years	41.14%	38.88% ★★★	41.52% ★★★	R
30-Day Follow-Up—Ages 18 to 64 Years	61.84%	60.96% ★★★	60.55% ★★★	R
7-Day Follow-Up—Ages 65 Years and Older	NA	NA	13.33% ★	R
30-Day Follow-Up—Ages 65 Years and Older	NA	NA	46.67% ★★	R
7-Day Follow-Up—Total	45.98%	42.74% ★★★	44.24% ★★★	R
30-Day Follow-Up—Total	67.21%	65.04% ★★★	64.52% ★★★	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	43.78%	37.42% ★★	38.82% ★★★	R
30-Day Follow-Up—Total	64.21%	59.43% ★★★	60.61% ★★★	R
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7-Day Follow-Up—Total	21.78%	23.27% ★★	26.61% ★★	R
30-Day Follow-Up—Total	42.33%	43.54% ★★	44.39% ★★	R
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	31.07% NC	21.57% ★★	R
30-Day Follow-Up—Total	—	48.22% NC	36.20% ★★★	R
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.81%	82.26% ★★★	82.20% ★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	75.21%	77.41% ★★★★★	75.61% ★★★★	R
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	75.68%	80.56% ★★★	77.14% ★★	R
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.98%	75.58% ★★★★★	75.08% ★★★★★	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose—1 to 11 Years	—	40.53% ★★	41.65% ★★	R
Blood Glucose—12 to 17 Years	—	58.50% ★★	55.05% ★	R
Blood Glucose—Total	—	52.71% ★★	50.48% ★	R
Cholesterol—1 to 11 Years	—	29.33% ★★	30.12% ★★	R
Cholesterol—12 to 17 Years	—	37.56% ★★	34.47% ★★	R
Cholesterol—Total	—	34.91% ★★	32.99% ★★	R
Blood Glucose and Cholesterol—1 to 11 Years	—	26.13% ★★	27.29% ★★	R
Blood Glucose and Cholesterol—12 to 17 Years	—	35.53% ★★	32.16% ★	R
Blood Glucose and Cholesterol—Total	—	32.50% ★★	30.50% ★★	R
Effectiveness of Care Domain: Overuse/Appropriateness				
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.43%	0.46% ★★	0.25% ★★★	R
Appropriate Treatment for Upper Respiratory Infection (URI)				
Ages 3 Months to 17 Years	90.33%	90.71% ★	89.88% ★	R
Ages 18 to 64 Years	80.56%	80.97% ★★	79.98% ★★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Ages 65 Years and Older	NA	65.79% ★★★	59.32% ★	R
Total	88.53%	88.58% ★★	87.52% ★★	R
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	73.27% NC	70.11% ★★	R
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage (Average MME ≥90)**	5.19%	4.15% ★★★	3.84% ★★★	R
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
Ages 3 Months to 17 Years	—	73.73% ★★★	77.02% ★★★	R
Ages 18 to 64 Years	—	39.45% ★★	39.53% ★★	R
Ages 65 Years and Older	—	26.32% ★	23.08% ★	R
Total	—	62.37% ★★★	64.78% ★★★	R
Access/Availability of Care Domain				
Initiation and Engagement of SUD Treatment (IET)				
Initiation of SUD Treatment—Total—Ages 13 to 17 Years	—	34.09% NC	28.12% ★	R
Engagement of SUD Treatment—Total—Ages 13 to 17 Years	—	12.50% NC	14.32% ★★★	R
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	—	36.68% NC	37.51% ★	R
Engagement of SUD Treatment—Total—Ages 18–64 Years	—	11.14% NC	11.52% ★★	R
Initiation of SUD Treatment—Total—Ages 65 Years and older	—	44.27% NC	39.75% ★★	R
Engagement of SUD Treatment—Total—Ages 65 Years and older	—	5.34% NC	3.73% ★★	R
Initiation of SUD Treatment—Total—Total	—	36.70% NC	36.65% ★	R
Engagement of SUD Treatment—Total—Total	—	11.05% NC	11.46% ★★	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	86.62% ★★★	86.37% ★★★	R
Postpartum Care	—	83.45% ★★★★	81.51% ★★★	R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Ages 1 to 11 Years	—	43.85% ★	46.74% ★★	R
Ages 12 to 17 Years	—	64.02% ★★★	53.72% ★★	R
Total	—	57.36% ★★	51.04% ★★	R
Utilization and Risk Adjusted Utilization Domain: Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	63.03%	65.93% ★★★★	66.40% ★★★★	R
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.60%	66.66% ★★	69.43% ★★★	R
Ambulatory Care (Per 1,000 Member Years) (AMB)				
*Emergency Department Visits—Total**	549.48	569.46 ★★	545.60 ★★	R
Outpatient Visits, Including Telehealth—Total	4,269.6	4,183.68 NC	4,143.82 NC	R
Inpatient Utilization—General Hospital/Acute Care (IPU)[1]				
Discharges per 1,000 Member Years—Total Inpatient—Total	70.68	63.22 NC	66.43 NC	R
Average Length of Stay—Total Inpatient—Total	5.55	5.36 NC	5.46 NC	R
Discharges per 1,000 Member Years—Maternity—Total	36.96	31.07 NC	27.76 NC	R
Average Length of Stay—Maternity—Total	2.38	2.43 NC	2.42 NC	R
Discharges per 1,000 Member Years—Surgery—Total	16.44	14.63 NC	15.55 NC	R
Average Length of Stay—Surgery—Total	9.82	9.23 NC	9.38 NC	R
Discharges per 1,000 Member Years—Medicine—Total	30.36	27.84 NC	32.09 NC	R

HEDIS Measures	MY 2021 HEDIS Rate	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2023 Audit Designation
Average Length of Stay—Medicine—Total	5.72	5.51 NC	5.34 NC	R
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	—	50.87% ★	51.48% ★	R
Ages 12 to 17 Years	—	55.80% ★★★	56.41% ★★★	R
Ages 18 to 21 Years	—	24.15% ★★★	24.75% ★★	R
Total	—	48.24% ★★★	49.09% ★★	R
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—18–64**	11.41%	8.39% NC	9.23% NC	R
*Expected Readmissions—18–64**	11.40%	10.92% NC	10.85% NC	R
*O/E Ratio—18–64**	1.00	0.7683 ★★★★★	0.8506 ★★★★	R
Measures Reported Using ECDS				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	31.81%	62.67% NC	62.28% ★★★★	R
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.00% NC	18.88% ★★★★	R
Follow-Up on Positive Screen	—	NA	NA	R
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	—	0.04% ★★	6.05% ★★★	R
Follow-Up on Positive Screen	—	NA	NA	R

[1] In the *Utilization* domain, the *Inpatient Utilization—General Hospital/Acute Care (IPU)* measure indicators capture the frequency of services provided. Higher or lower numbers for these indicators do not necessarily indicate better or worse performance. These numbers are provided for information only.
* For this indicator, a lower rate indicates better performance.
NA indicates that the MCO(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that a comparison to the HEDIS MY 2023 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO(s).
HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

HSAG is presenting only MCO-reported Core Set measure rates that have undergone independent validation. **UHCCP**'s rates on DHHS-required Adult and Child Core Set measures have not been independently validated to confirm that they were calculated in accordance with Core Set specifications and are reportable. Therefore, HSAG is not presenting **UHCCP**'s unvalidated Core Set measure rates in this report.

Strengths

Effectiveness of Care Domain: Prevention and Screening

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*; *Immunizations for Adolescents—Combination 1* and *Combination 2*; *Lead Screening in Children*; and *Colorectal Cancer Screening—Ages 46 to 50 Years, Ages 51 to 75 Years,* and *Total* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* and *Colorectal Cancer Screening—Ages 46 to 50 Years, Ages 51 to 75 Years,* and *Total* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Immunizations for Adolescents—Combination 1* and *Combination 2* and *Lead Screening in Children* measure indicators. The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10* rates demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease. The *Immunizations for Adolescents—Combination 1* and *Combination 2* rates demonstrate that adolescents were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. The *Lead Screening in Children* rate demonstrates that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. Lastly, the *Colorectal Cancer Screening* rates demonstrates that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality, Timeliness, and Access]**

Effectiveness of Care Domain: Respiratory Conditions

The *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years*; *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*; *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*; and *Asthma Medication Ratio—Ages 5 to 11 Years, Ages 12 to 18 Years, Ages 19 to 50 Years, Ages 51 to 64 Years,* and *Total* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*; *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*; and *Asthma*

Medication Ratio—Ages 12 to 18 Years, Ages 19 to 50 Years, and *Total* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years*; *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*; and *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 51 to 64 Years* indicators. The *Appropriate Testing for Pharyngitis—Ages 18 to 64 Years* rate demonstrates that **UHCCP** providers were appropriately prescribing antibiotics and ordering a group A streptococcus test for pharyngitis episodes. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* rate demonstrates that **UHCCP** providers were conducting spirometry testing to diagnose COPD, as recommended by the Global Initiative for Chronic Obstructive Lung Disease.[24] The *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* rates demonstrate that **UHCCP** providers were appropriately prescribing medication to help members control their COPD. Lastly, the *Asthma Medication Ratio* rates demonstrate that **UHCCP** providers effectively managed this treatable condition for members with persistent asthma. **[Quality, Timeliness, and Access]**

Effectiveness of Care Domain: Cardiovascular Conditions

The *Controlling High Blood Pressure* measure was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for this measure. The rate for this measure demonstrates that **UHCCP** providers helped members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality and Timeliness]**

Effectiveness of Care Domain: Diabetes

The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)*, *Blood Pressure Control for Patients With Diabetes—Blood Pressure (<140/ 90 mm Hg)*, and *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for these measure indicators. The *Hemoglobin A1c Control for Patients With Diabetes* rates demonstrate that **UHCCP** providers helped members effectively control their blood glucose levels, reducing the risk of complications. The *Blood Pressure Control for Patients With Diabetes* rate demonstrates that **UHCCP** providers helped adult members with diabetes adequately control their blood pressure. Lastly, the *Eye Exam for Patients With Diabetes* rate demonstrates that **UHCCP** providers ensured that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**

Effectiveness of Care Domain: Behavioral Health

For the following measure indicators, **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark:

[24] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, and Prevention of Chronic Obstructive Pulmonary Disease."

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* **[Quality]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total)* and *30-Day Follow-Up (Ages 6 to 17, Ages 18 to 64,* and *Total)* **[Quality, Timeliness, and Access]**
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* **[Quality, Timeliness, and Access]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **[Quality, Timeliness, and Access]**
- *Diabetes Monitoring for People With Diabetes and Schizophrenia* **[Quality]**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **[Quality and Access]**

The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* rates demonstrate that **UHCCP** providers were effectively treating adult members diagnosed with major depression by prescribing antidepressant medication and helping them remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (Ages 6 to 17 Years, Ages 18 to 64 Years,* and *Total)* and *30-Day Follow-Up (Ages 6 to 17 Years, Ages 18 to 64 Years,* and *Total)* rates demonstrate that **UHCCP** providers ensured that members hospitalized for mental illness received adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. Additionally, the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and the *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total* rates demonstrate that **UHCCP** providers effectively managed care for patients discharged after an ED visit for mental illness and substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**

Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes and cardiovascular disease. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People With Diabetes and Schizophrenia* rates demonstrate that **UHCCP** providers ensured that adult members on antipsychotics were properly screened and monitored to promote positive health outcomes for this population. **[Quality, Timeliness, and Access]**

The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* rate demonstrates that **UHCCP** providers ensured that members with schizophrenia or schizoaffective disorder adhered to their treatment plan and continued to use prescribed antipsychotic medications. **[Quality and Access]**

Effectiveness of care Domain: Overuse/Appropriateness

The *Non-Recommended Cervical Cancer Screening in Adolescent Females, Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years*, *Use of Opioids at High Dosage,* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for these measure indicators. The *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate demonstrates that **UHCCP** providers were avoiding unnecessary cervical cancer screenings for adolescent females. The *Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years* rate demonstrates that, for this age group, **UHCCP** providers effectively managed the dispensing of antibiotic medication to treat URI. The *Use of Opioids at High Dosage* rate demonstrates that **UHCCP** providers prevented or minimized the prescribing of opioids at a dosage of ≥ 90 mg morphine equivalent dose. The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Total* rates demonstrate that **UHCCP** providers effectively prevented or minimized the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**

Access/Availability of Care Domain

The *Engagement of SUD Treatment—Total—Ages 13 to 17 Years* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for these measure indicators. The *Engagement of SUD Treatment—Total—Ages 13 to 17 Years* rate demonstrates that **UHCCP** providers effectively engaged members with a new SUD episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates demonstrate that **UHCCP** providers ensured that members received timely and adequate prenatal and postpartum care, in alignment with guidance provided by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**

Utilization and Risk Adjusted Utilization Domain: Utilization

The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits,* and *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicators were a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicators. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates show that **UHCCP** providers ensured that children were seen by a PCP within the first 30 months of life to assess and influence members' early development. The *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* rate indicates that

UHCCP providers were effective in ensuring that adolescents received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization

The *Plan All-Cause Readmissions—Observed/Expected Ratio—Total* measure indicator was a strength for **UHCCP**. **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark on this indicator. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. The rate on this measure indicator demonstrates that **UHCCP** providers had the appropriate processes in place to effectively coordinate care and provide support for members post-discharge. **[Quality]**

Measures Collected Using ECDS Domain

The *Breast Cancer Screening, Prenatal Depression Screening and Follow-Up—Depression Screening,* and *Postpartum Depression Screening and Follow-Up—Depression Screening* measure indicators were a strength for **UHCCP**. **UHCCP** ranted at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 75th percentile benchmark for the *Breast Cancer Screening* and *Prenatal Depression Screening and Follow-Up—Depression Screening* measure indicators, and ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 50th percentile benchmark for the *Postpartum Depression Screening and Follow-Up—Depression Screening* measure indicator. The *Breast Cancer Screening* rate demonstrates that **UHCCP** providers were effective in ensuring that women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years. The *Prenatal Depression Screening and Follow-Up—Depression Screening* rate indicates that **UHCCP** providers were screening members appropriately for clinical depression while pregnant. In addition, the *Postpartum Depression Screening and Follow-Up—Depression Screening* rate indicates that **UHCCP** providers were screening members appropriately for clinical depression during the postpartum period. **[Quality and Timeliness]**

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care Domain: Prevention and Screening

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total;* and *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. HSAG recommended that **UHCCP** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, HSAG recommended that **UHCCP** providers follow up annually with sexually active members through various modes of communication to ensure members return for a yearly screening. **[Quality]**

Effectiveness of Care Domain: Behavioral Health

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older, Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—12 to 17 Years* and *Total,* and *Blood Glucose and Cholesterol—12 to 17 Years* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. To improve rates on the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older* measure indicator, HSAG recommended that **UHCCP** and its providers implement interventions to ensure that discharged members ages 65 years or older with a diagnosis of mental illness or intentional self-harm receive follow-up care with a mental health provider within seven days of discharge. Providing timely follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization. To improve rates on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose—12 to 17 Years* and *Total,* and *Blood Glucose and Cholesterol—12 to 17 Years* measure indicators, HSAG recommended that **UHCCP** and its providers identify root causes and implement interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality, Timeliness, and Access]**

Effectiveness of Care Domain: Overuse/Appropriateness

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Ages 65 Years and Older* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Ages 65 Years and Older* rates suggest that a diagnosis of URI resulted in an antibiotic dispensing event for child, adolescents, and older adults. HSAG recommended that **UHCCP** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommended that **UHCCP** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. To improve rates on the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older* measure indicator, HSAG recommended that **UHCCP** conducts data analysis across key demographics such as race, ethnicity, age, and ZIP Code to identify issues with antibiotics prescribing practices and implement targeted interventions. **[Quality]**

Access/Availability of Care Domain

The *Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators. HSAG recommended that **UHCCP** determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment. Early and regular SUD treatment, including

medication therapy, has been demonstrated to improve outcomes for individuals with SUDs. **[Quality, Timeliness, and Access]**

Utilization and Risk Adjusted Utilization Domain: Utilization

The *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* measure indicator was a weakness for **UHCCP**. The rate for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark. Well-care visits provide an opportunity for providers to provide screening and counseling. HSAG recommended that **UHCCP** implement targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. HSAG also recommended that **UHCCP** identify best practices for ensuring children receive timely and medically appropriate well-care services. **[Quality and Access]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-11 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table C-11—Follow-Up on Prior Year's Recommendations for Performance Measures

***Recommendation* (Effectiveness of Care: Prevention and Screening Domain)**
The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for these measure indicators. HSAG recommends that **UHCCP** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, HSAG recommends that **UHCCP** providers follow up annually with sexually active members through various modes of communication to ensure members return for yearly screening.
Response
Describe initiatives implemented based on recommendations: *WCC-BMI Total* –**UHCCP** implemented multi-faceted activities and/or interventions to address recommendations for the identified HEDIS measure. This includes but is not limited to the following: Provider driven activities and/or interventions: • **UHCCP** annually distributes, via our online provider website, reference guidelines (UHC PATH Guides) which are designed to help providers better understand the specifications for many of the quality measurement programs and tools used to address care opportunities, as well as how to report data and related billing codes. • **UHCCP** offers on-demand training via our provider website and monthly live provider education on several topics, including coaching on HEDIS measure gap closure. • **UHCCP** engages with providers in Value Base Contracting (VBC) to promote HEDIS measure gap closure.

- **UHCCP** Clinical Practice Consultants (CPC) regularly engage with providers and offer education on HEDIS measure gap closure. Specific to the WCC-BMI Total HEDIS measure, the CPCs discuss with providers the importance of documenting an individual's body mass index as percentiles in their medical record in accordance with NCQA guidance.
- **UHCCP** CPCs review Patient Care Opportunity Reports (PCOR) with providers during recurrent meetings. The PCOR is a monthly comprehensive report which allows providers to get details about preventive care opportunities for their patients who are **UHCCP** members. The PCOR shows current, at-a-glance details about plan members' open care opportunities based on medical and pharmacy claims data and supplemental data received from providers. This information gives providers a more complete picture about their members' health and overall quality of care.
- Clinical Transformation Consultants (CTC) participate in quarterly Joint Operating Committee meetings and deliver provider education, as necessary.

Member driven activities and/or interventions:

- **UHCCP** attempts to close open gaps in care at every member telephonic touchpoint, including when a member calls customer service or speaks with someone on the local case/care management team.
- **UHCCP** utilizes various communication campaigns (i.e., interactive voice recording reminders, education mailers, etc.) with the main purpose of prompting members to schedule appointments and closing the identified gap in care. These outreach campaigns are designed to be member centric and are deployed based on the individual's communication preferences.
- **UHCCP** offers member incentives in the form of gift cards to individuals who schedule and attend an appointment to complete their annual well child visit. The member incentive program is based off of the Child & Adolescent Well-Care Visits (WCV) measure specifications to ensure all children and adolescents are reminded of the need for annual preventative checkups.
- **UHCCP** provides member education via the 2024 UHCCP Heritage Health Member Handbook (pgs. 34-36) regarding the importance of the annual well child visit and includes language specifically addressing that the exam should incorporate weight assessment as well as counseling for nutrition and physical activity.

Internal program/process activities and/or interventions:

- **UHCCP** addresses identified language disparities via targeted telephonic outreaches through its NCQA Health Equity Accreditation program. Program activities were based off of the WCV measure specifications to ensure all children and adolescents are reminded of the need for annual preventative checkups

Chlamydia Screening – **UHCCP** implemented multi-faceted activities and/or interventions to address recommendations for the identified HEDIS measure. This includes but is not limited to the following:

Provider driven activities and/or interventions:

- **UHCCP** annually distributes UHC PATH Guides via our online provider website.
- **UHCCP** offers on-demand training via our provider website and monthly live provider education on several topics, including coaching on HEDIS measure gap closure.
- **UHCCP** engages with providers in VBC to promote HEDIS measure gap closure.
- **UHCCP** CPCs review PCORs with providers during recurrent meetings.
- **UHCCP** endorses provider use of evidence-based CPGs from nationally recognized sources. In 2024, **UHCCP** recognized the use of U.S. Preventive Services Task Force (USPSTF), Recommendations for Primary Care Practice guidelines which provides advice on chlamydia/gonorrhea screening best practices.

- In May 2024, Matthew Donahue, MD, State Epidemiologist, Division of Public Health, Nebraska Department of Health & Human Services provided the **UHCCP** Clinical & Provider Advisory Committee (CPAC) with a presentation on the prevalence of sexually transmitted diseases (STI) in Nebraska. The presentation was intended to bring awareness to related trends and begin the discussion on collaborative initiatives that could be implemented to improve health outcomes.

Member driven activities and/or interventions:

- **UHCCP** attempts to close open gaps in care at every member telephonic touchpoint, including when a member calls customer service or speaks with someone on the local case/care management team.
- **UHCCP** utilizes various communication campaigns (i.e., interactive voice recording reminders, education mailers, etc.) with the main purpose of prompting members to schedule appointments and closing the identified gap in care.
- **UHCCP** offers member incentives in the form of gift cards to individuals who schedule and attend an appointment to complete their annual chlamydia screening.
- The **UHCCP** case/care management team conducts targeted telephonic outreach to members eligible for the HEDIS measure to provide education on the importance of annual screening, assist in scheduling an appointment to close the gap in care, and address any identified social determinate of health (SDoH) barriers (i.e., lack of reliable transportation)

Internal program/process activities and/or interventions:

- **UHCCP** initiated clinical pathway projects with local community-based organizations that focused on STI treatment and education, mental health support and education, and SDoH resource connectivity.

UHCCP Health Equity Manager attended a presentation on the topic of Black Sexual & Mental Health hosted by the University of Nebraska-Lincoln's, Minority Health Disparities Initiative with the intention of implementing lessons learned into future NCQA Health Equity Accreditation program initiatives.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
WCC-BMI Total – In 2023, the health plan noted a year-over-year increase in total BMI's documented of 2.19 percentage points from 2022.

Chlamydia Screening – In 2023, the health plan noted that rates continue to trend downward in chlamydia screening for women ages 16-24. Year-over-year rates demonstrated a 0.27 percentage point decrease for women ages 16-20, and a 0.06 percentage point decrease for both women ages 21-24 and total ages 16-24.

Identify any barriers to implementing initiatives:
WCC-BMI Total – Identified barriers to HEDIS gap closure includes but is not limited to:

- Incomplete claims submission which necessitates a manual medical record review of provider documentation prior to gap closure.
- Documenting an individual's body mass index as percentiles within the member's medical record which is misaligned with NCQA guidance on gap closure.

Chlamydia Screening – Identified barriers to HEDIS gap closure includes but is not limited to:

- Individuals obtaining screening and treatment from providers (i.e., free clinics) that do not rely on **UHCCP** for payment of services. Therefore, **UHCCP** is unable to confirm if testing took place via claims submission.
- Social/interpersonal/cultural stigmatization regarding STI testing and treatment.
- Employing activities and/or interventions that address proper preventive screening for minors (16-18 yrs) that do not also violate the trust relationship of the members' legal guardians/representatives.

- Interruption in care coordination related to provider clinics who complete testing but refer members to another provider to seek treatment.

Public testing centers (i.e., local county clinics) have limited appointment availability, do not allow dependent children to attend appointments, and at times require out of pocket payment for services.

Identify strategy for continued improvement or overcoming identified barriers:
WCC-BMI Total – **UHCCP**'s strategy to address identified barriers, includes the continued deployment of the implemented provider and member driven activities and/or interventions for the *WCC-BMI Total* HEDIS measure as described in this response. Additionally, **UHCCP** will include education articles in the quarterly member newsletters which will cover topics on the importance of the annual child/adolescent well visit.

Chlamydia Screening – **UHCCP**'s strategy to address identified barriers, includes the continued deployment of the implemented provider and member driven activities and/or interventions for the *Chlamydia Screening* HEDIS measure as described in this response. In addition to these efforts **UHCCP** will also:

- Include education articles in the quarterly member newsletters which will cover topics on the importance of annual chlamydia screening.
- Leverage national company quality improvement campaigns offering in-home chlamydia testing kits.

Launch a collaborative Performance Improvement Project with contract Nebraska Heritage Health managed care organizations (MCO) designed to improve rates of chlamydia screening.

HSAG Assessment:

UHCCP did not sufficiently address CY 2023–2024 recommendations regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. **UHCCP**'s performance on this indicator improved from MY 2022 to MY 2023, but remains below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes the initiatives **UHCCP** launched to improve performance on this indicator, including provider/member engagement, provider/member education, and member incentives, and recommends that **UHCCP** continue these efforts.

UHCCP did not sufficiently address the CY 2023–2024 recommendations regarding the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators. **UHCCP**'s performance on these indicators was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes the initiatives **UHCCP** launched to improve performance on these indicators, including provider/member engagement, provider/member education, and member incentives, and recommends that **UHCCP** continue these efforts.

***Recommendation* (Effectiveness of Care: Respiratory Conditions Domain)**

The *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicator was a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. The rate of this measure indicator suggests that child and adolescent members did not receive proper testing to merit antibiotic treatment for pharyngitis HSAG recommends that **UHCCP** work with providers to determine whether children and adolescents are properly tested to prevent the unnecessary use of antibiotics.

Response

Describe initiatives implemented based on recommendations: **UHCCP** implemented multiple activities and/or interventions to address recommendations for the identified HEDIS measure. This includes but is not limited to the following:

Provider driven activities and/or interventions:

- **UHCCP** annually distributes UHC PATH Guides via our online provider website.
- **UHCCP** offers on-demand training via our provider website and monthly live provider education on several topics, including coaching on HEDIS measure gap closure.
- **UHCCP** engages with providers in VBC to promote HEDIS measure gap closure.
  UHCCP CPCs review PCORs with providers during recurrent meetings.

UHCCP's Chief Medical Officer provided live training on appropriate antibiotic prescribing practices in November 2022 and October 2023.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

In 2023, the health plan noted a statistically significant increase of 11.64% in *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* from 2022.

Identify any barriers to implementing initiatives:

Identified barriers to HEDIS gap closure includes but is not limited to:

- Insufficient member knowledge on the importance of proper use of antibiotics and requesting pharmaceutical remedy prior to testing. This can lead to abrasion as many providers want to provide a positive member experience with their clinic while also trying to adhere to evidence-based practices.
- Providing pharmaceutical treatment to individuals who are showing signs of illness prior to testing due to a confirmed case within the household as a preventative measure.

Limited capability to complete testing during virtual health care appointments.

Identify strategy for continued improvement or overcoming identified barriers:

UHCCP's strategy to address identified barriers, includes the continued deployment of the implemented activities and/or interventions for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* HEDIS measure as described in this response. Additionally, **UHCCP** will include education articles in the quarterly member newsletters which will cover topics such as proper use of antibiotics.

HSAG Assessment:

UHCCP sufficiently address the CY 2023–2024 recommendations regarding the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicator. **UHCCP**'s performance on this indicator improved from MY 2022 to MY 2023 and is now above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark.

***Recommendation* (Effectiveness of Care: Overuse/Appropriateness Domain)**

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **UHCCP**. **UHCCP** ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark for this measure indicator. The rate for this measure indicator suggests that a diagnosis of URI resulted in an antibiotic dispensing event for child and adolescent members. HSAG recommends that **UHCCP** conduct a root cause analysis to ensure that providers are aware of appropriate treatments for URI. Additionally, HSAG recommends that **UHCCP** providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.

Response

Describe initiatives implemented based on recommendations:

UHCCP implemented multiple activities and/or interventions to address recommendations for the identified HEDIS measure. This includes but is not limited to the following:

Provider driven activities and/or interventions:

- **UHCCP** annually distributes UHC PATH Guides via our online provider website.
- **UHCCP** offers on-demand training via our provider website and monthly live provider education on several topics, including coaching on HEDIS measure gap closure.
- **UHCCP** engages with providers in VBC to promote HEDIS measure gap closure.
- **UHCCP** CPCs review PCORs with providers during recurrent meetings.
- **UHCCP** promoted proper use of antibiotics via an educational article posted on the provider website titled *Improve Antibiotic Use, Improve Health Equity*. Published during the 2023 U.S. Antibiotic Awareness week, the article outlines the overuse of antibiotics by providers in Nebraska and includes guidance on appropriate antibiotic prescribing practices.

UHCCP's Chief Medical Officer provided live training on appropriate antibiotic prescribing practices in November 2022 and October 2023.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

In 2023, the health plan noted a statistically significant decrease of 0.83% in *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Year* from 2022.

Identify any barriers to implementing initiatives:

Identified barriers to HEDIS gap closure includes but is not limited to:

- Low provider utilization of live training sessions.
- Insufficient member knowledge on the importance of proper use of antibiotics and requesting pharmaceutical remedy prior to testing. This can lead to abrasion as many providers want to provide a positive member experience with their clinic while also trying to adhere to evidence-based practices.
- Providing pharmaceutical treatment to individuals who are showing signs of illness prior to testing due to a confirmed case within the household as a preventative measure.

Limited capability to complete testing during virtual health care appointments.

Identify strategy for continued improvement or overcoming identified barriers:

UHCCP's strategy to address identified barriers, includes the continued deployment of the implemented activities and/or interventions for the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* HEDIS measure as described in this response. Additionally, **UHCCP** will include education articles in the quarterly member newsletters which will cover topics such as proper use of antibiotics.

HSAG Assessment:

UHCCP did not sufficiently address the CY 2023–2024 recommendations regarding the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator. **UHCCP**'s performance on this indicator was consistent from MY 2022 to MY 2023 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2022 25th percentile benchmark. HSAG recognizes the initiatives **UHCCP** launched to improve performance on this indicator, including provider engagement and education, and recommends that **UHCCP** continue these efforts.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table C-12—Compliance With Regulations—Trended Performance for UHCCP

Standard and Applicable Review Years*	Year One (CY 2022–2023)**	Year Two (CY 2023–2024)**	Year Three (CY 2024–2025)**
Standard Number and Title	**UHCCP Results**		
Standard I—Enrollment and Disenrollment	100%		
Standard II—Member Rights and Confidentiality		100%	100%
Standard III—Member Information		100%	95.5%
Standard IV—Emergency and Poststabilization Services	100%		100%
Standard V—Adequate Capacity and Availability of Services		100%	
Standard VI—Coordination and Continuity of Care		100%	100%
Standard VII—Coverage and Authorization of Services		84.2%	94.7%
Standard VIII—Provider Selection and Program Integrity	94%		
Standard IX—Subcontractual Relationships and Delegation	75%		
Standard X—Practice Guidelines	100%		100%
Standard XI—Health Information Systems	100%		
Standard XII—Quality Assessment and Performance Improvement	100%		
Standard XIII—Grievance and Appeal System		100%	100%

*Bold text indicates standards that HSAG reviewed during CY 2023–2024.
**Grey shading indicates standards for which no comparison results are available.

Strengths

UHCCP submitted a large body of evidence to substantiate compliance with each standard reviewed. Submissions included policies, procedures, reports, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality]**

Five out of seven standards met 100 percent compliance and identified no required actions. **[Quality, Timeliness, and Access]**

UHCCP achieved full compliance for the Member Rights and Confidentiality standard, indicating members are receiving timely and adequate access to information that can assist them in accessing care and services. **[Access]**

UHCCP achieved full compliance for the Emergency and Poststabilization Services standard, demonstrating the MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. **[Timeliness and Access]**

UHCCP achieved full compliance for the Coordination and Continuity of Care standard, demonstrating the MCO had adequate processes in place for its care management program. **[Quality, Timeliness, and Access]**

UHCCP achieved full compliance for the Practice Guidelines standard, demonstrating the MCO had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. **[Quality]**

UHCCP achieved full compliance for the Grievance and Appeal System standard, demonstrating the MCO had processes in place for handling member complaints, grievances, and appeals. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

UHCCP should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes. **[Quality]**

UHCCP received a score of 95.5 percent for the Member Information standard. As a result, HSAG recommended that **UHCCP** review the specialist letter and modify the language for clarity. The letter indicated that "[i]f you are in active treatment, such as care if you are pregnant, you can continue to see your doctor until your visit to the doctor after your baby is born or up to 90 days for other ongoing care." Additionally, **UHCCP** must consider all areas where member materials are provided in electronic format and include the statement, "information is available in paper form without charge upon request and is to be provided within five business days." The MCO must make information available electronically, and information provided electronically must meet the following requirements:

- The format is readily accessible. (Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium's [W3C's] Web Content Accessibility Guidelines.)
- The information is placed in a website location that is prominent and readily accessible.
- The information can be electronically retained and printed.
- The information complies with content and language requirements.

- The member is informed that the *information is available in paper form without charge upon request and is to be provided within five business days.* **[Access]**

UHCCP received a score of 94.7 percent for the Coverage and Authorization of Services standard. As a result, HSAG recommended that **UHCCP** revise their OptumRx Delegated UnitedHealthcare Prior Authorization Policy and Procedure to include that the plan is to provide a response to a request for prior authorization within 24 hours, by telephone or another telecommunication device. Following the review, **UHCCP** submitted an updated policy that now includes the method of communication for responding to providers. Additionally, **UHCCP** must mail the NABD within the following time frames:

- For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization.
- For expedited service authorization decisions, within 72 hours of the request for authorization.
- For service authorization decisions not reached within the 14-calendar-day or 72-hour time frames, on the date these time frames expire. **[Timeliness and Access]**

For the Practice Guidelines standard, HSAG recommended that **UHCCP** make the practice guidelines available and accessible to all members and potential members on the **UHCCP** Nebraska public member website. **[Quality]**

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-13 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table C-13—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendation
UHCCP should review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes.
Response
Describe initiatives implemented based on recommendations: **UHCCP** received the Contract Year 2023-2024 Compliance Review Report on December 11, 2023. Response to all Required Corrective Actions were due on February 9, 2024. **UHCCP** has a comprehensive process for tracking any issues identified in an audit or regulatory review. This Corrections process includes tracking of each issue in an internal data warehousing system until the item is completed. To close out an item there must be evidence of completion, such as a revised document, new training content, etc. This evidence is also stored in the internal data warehousing system. A staff person on the Corrections team monitors each item with the subject matter experts to ensure timely submission of all required elements to the applicable regulatory entity. This commitment to timely completion of corrective actions positively impacts member outcomes for any corrective actions that involve a member-facing process. Utilizing

the Corrections process resulted in all required responses from the Contact Year 2023-2024 Compliance Review Report were submitted by the due date of February 9. 2024.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** will continue to use its internal Corrections process to track corrective actions to completion so that future audit deliverables continue to be submitted in a timely manner.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
UHCCP received a score of 83.3 percent for the Member Rights and Confidentiality standard. **UHCCP** must ensure policies and procedures, and other applicable documents, including the member handbook and provider manual, include the provision for a member to request and receive a copy of his or her medical records and request that they be amended or corrected.
Response
Describe initiatives implemented based on recommendations: In 2024 pursuant to the CAP resolution, a Member Rights and Responsibilities Policy was drafted to ensure all federal, contractual and Nebraska Administrative Code Rights and Responsibilities requirements are addressed. A Member Rights and Responsibilities Standard Operating Procedure (SOP) was drafted to ensure consistency in the verbiage used related to the Member Rights and Responsibilities in the Member Handbook, the Member Website, and the Provider Manual. The Member Rights and Responsibilities in all applicable documents and the website were updated in the spring of 2024. The updated member handbook with this verbiage can be found on the member website and was reviewed as part of the 2024 HSAG Compliance review.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Continuing to follow Section V.F.4.d of contract 102889 O4, which states that the MCO must review and update the member handbook annually. Also, in this section it states that as part of this annual review, the MCO must submit the updated handbook to MLTC for review and approval. The annual review by the MCO and annual review/approval by MLTC are utilized to monitor compliance with contractual requirements. In addition, the annual review of the Member Rights and Responsibilities policy to ensure it still follows all federal, contractual and Nebraska Administrative Code Rights and Responsibilities requirements.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
UHCCP received a score of 77.3 percent for the Member Information standard. HSAG recommended that **UHCCP** update the member handbook to include the language "rescheduling an appointment, rather than being a no-show," so that the member is informed that they also have an option to reschedule. Additionally, HSAG

recommended that in order to thoroughly inform the member, the member handbook should also include requirements about where a member can seek assistance in executing an advance directive, and to whom copies should be given. The member handbook lacked information about to whom advance directive copies should be given. Also, for the Member Information standard, **UHCCP** must update policies, the member handbook, and other applicable documents/notices informing members that **UHCCP** will make interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language, and written translation is available in prevalent languages, and how to access these services. This includes oral interpretation and use of auxiliary aides such as Teletypewriters/Telecommunications Device for the Deaf (TTY/TDY) and ASL. Additionally, the MCE must notify members that auxiliary aides and services are available upon request and at no cost for members with disabilities, and how to access them. In addition, the MCE must follow policies and procedures to give members written notice of any significant change in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change. Moreover, the MCE must update the member handbook informing members of the following:

- The definition of "State fair hearing."
- Information on how to report suspected fraud or abuse, which must include MLTC's toll-free number.
- Make information available to members, upon, request, to include the structure and operation of the MCE.

Response

Describe initiatives implemented based on recommendations:

The Section 1557 and taglines document was revised to ensure all requirements found in the MCO contract and federal regulations were met, including specific verbiage indicating American Sign Language is available at no charge to the member. The revised document was submitted to MLTC for approval on 1/19/24 and was approved by MLTC on 1/26/24. The document was subsequently added to the member handbook, provider directory and all other required documents. The updated member handbook with this document can be found on the member website and was reviewed as part of the 2024 HSAG Compliance review.

The member handbook was updated to include the definition of State Fair Hearing following the virtual onsite in 2023. The member handbook with this revision was submitted with **UHCCP** of NEs CAP response on 2/9/24.

The member handbook was updated in 2024 to include MLTC's toll-free number for reporting suspected fraud or abuse. The member handbook with this revision was submitted with **UHCCP** of NEs CAP response on 2/9/24. The updated member handbook with this verbiage can be found on the member website and was reviewed as part of the 2024 HSAG Compliance review.

Following the virtual onsite in 2023, the member handbook was updated to that members have the right to request information about the structure and operation of the MCO.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Not applicable.

Identify any barriers to implementing initiatives:

Not applicable.

Identify strategy for continued improvement or overcoming identified barriers:

Continuing to follow Section V.F.4.d of contract 102889 O4, which states that the MCO must review and update the member handbook annually. Also, in this section it states that as part of this annual review, the MCO must submit the updated handbook to MLTC for review and approval. The annual review by the MCO and annual review/approval by MLTC are utilized to monitor compliance with contractual requirements.

HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.
Recommendation
UHCCP received a score of 96.2 percent for the Grievance and Appeal System standard. HSAG recommended that **UHCCP** review the grievance and appeal processes within the United Healthcare Appeals Grievances Introduction PowerPoint to differentiate the time frame requirements for accepting, acknowledging, and responding to member grievances and requests for appeals. In addition, HSAG recommended **UHCCP** include information in the member handbook and provider manual regarding the time frame for acknowledging a grievance. Also, HSAG recommended that **UHCCP** include information related to the timely filing requirement (defined as on or before the later of the following: within 10 days of the MCE mailing the NABD; the intended effective date of the proposed ABD) for requesting continuation of benefits/services while the MCE-level appeal is pending. Furthermore, **UHCCP** will need to update the tracking and monitoring mechanism to resolve standard appeals within the required time frame. The MCE must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 30 calendar days from the day the MCE receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the MCE receives the appeal. • For notice of an expedited resolution, the MCE must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member.
Response
Describe initiatives implemented based on recommendations: The report submitted during the 2023 audit did not exhibit the required metric of 30 calendar days for standard resolution of appeals as outlined in the contract. The internal report was updated to reflect the correct metric of 30 calendar days for standard resolution of appeals and the updated report format was submitted as evidence with **UHCCP** of NE's CAP responses on February 9, 2023.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** of NE will continue use of the monitoring report that was revised pursuant to the CAP to ensure all contractual and regulatory appeals timeframes are accurate.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2023–2024 recommendation.

Validation of Network Adequacy

Results

Findings on the Information Systems Capabilities Assessment

HSAG completed an ISCA for **UHCCP** and presented the ISCA findings and assessment of any concerns related to data sources used in the NAV to DHHS and **UHCCP**.

- HSAG evaluated the information systems data processing procedures and personnel that **UHCCP** had in place to support network adequacy indicator reporting. HSAG identified no concerns with **UHCCP**'s information systems data processing procedures and personnel.
- HSAG evaluated the information systems and processes used by **UHCCP** to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG identified no concerns with **UHCCP**'s enrollment data capture, data processing, data integration, data storage, or data reporting.
- HSAG evaluated the information systems and processes used by **UHCCP** to capture provider data as well as **UHCCP**'s provider data system(s), and did not identify concerns with provider data capture, data processing, data integration, data storage, or data reporting.
- HSAG did not identify any delegated entity network adequacy data-related items for **UHCCP** requiring corrective action during the review period. HSAG identified no concerns with **UHCCP**'s network adequacy methods or indicator reporting processes.

Overall, HSAG determined that **UHCCP**'s data collection procedures, network adequacy methods, and network adequacy results were acceptable.

Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **UHCCP** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table C-14 summarizes HSAG's validation ratings for **UHCCP** by indicator type, with **UHCCP** receiving *High Confidence* for all access and availability and time and distance indicators.

Table C-14—Summary of UHCCP's Validation Findings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time and Distance (n = 43)	100%	0%	0%	0%
Access and Availability (n = 17)	100%	0%	0%	0%

N = the number of indicators of that type.

Geographic Analysis

DHHS has set geographic access standards that require a provider within a maximum number of miles from the member's residence, which can vary by urbanicity (i.e., by whether the member lives in a county designated as urban, rural, or frontier). As mentioned previously, the exception is for access to hospitals, for which the standard is defined in terms of a maximum travel time (30 minutes) from the member's residence.

Table C-15 displays the percentage of each **UHCCP**'s members with access to providers in compliance with the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed by urbanicity; otherwise, results were reported statewide.

Table C-15–Percentage of UHCCP Members with Required Access to Care by Provider Category

Provider Category	Percentage of Members With Required Access*
PCP, Urban	>99.9%
PCP, Rural	100.0%
PCP, Frontier	100.0%
High-Volume Specialists**	
Cardiology	>99.9%
Neurology	99.9%
OB/GYN	99.8%
Oncology-Hematology	99.5%
Orthopedics	100.0%
Pharmacy, Urban***	95.9%
Pharmacy, Rural***	91.2%
Pharmacy, Frontier***	97.3%
All Behavioral Health Inpatient and Residential Service Providers, Urban	97.3%
All Behavioral Health Inpatient and Residential Service Providers, Rural	92.6%
All Behavioral Health Inpatient and Residential Service Providers, Frontier	70.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Urban	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Rural	>99.9%
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	98.0%
Hospitals	97.3%
Optometry, Urban	>99.9%
Optometry, Rural	>99.9%
Optometry, Frontier	100.0%

Provider Category	Percentage of Members With Required Access*
Ophthalmology, Urban	98.0%
Ophthalmology, Rural	>99.9%
Ophthalmology, Frontier	90.7%
Dental	
Dentist, Urban	100.0%
Dentist, Rural	99.9%
Dentist, Frontier	100.0%
Dental Specialists	
Oral Surgeon, Urban	66.5%
Oral Surgeon, Rural	58.5%
Oral Surgeon, Frontier	20.9%
Orthodontist, Urban	79.2%
Orthodontist, Rural	45.2%
Orthodontist, Frontier	32.5%
Periodontist, Urban	76.1%
Periodontist, Rural	36.8%
Periodontist, Frontier	0.0%
Pediadontist, Urban	93.6%
Pediadontist, Rural	73.6%
Pediadontist, Frontier	85.6%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type in a specific urbanicity.
*The minimum access is required for 100 percent of members unless otherwise noted.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.
***For pharmacies, the standard must be met for 90 percent of members within urban counties, or 70 percent of members in rural and frontier counties.

Table C-16 presents the percentage of **UHCCP**'s members with the access to care required by contract standards for behavioral health categories by Behavioral Health Region.

Table C-16–Percentage of UHCCP Members with Required Access to Inpatient and Residential Service Providers by Behavioral Health Region

Provider Category	Percentage of Members With Required Access*
All Behavioral Health Inpatient and Residential Service Providers	
Region 1	6.1%
Region 2	100.0%
Region 3	100.0%

Provider Category	Percentage of Members With Required Access*
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%
All Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	98.6%
Region 3	100.0%
Region 4	99.9%
Region 5	100.0%
Region 6	100.0%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.
*The minimum access is required for 100 percent of members.

Counties Not Meeting Geographic Access Standards by Population, Provider Category, Urbanicity, and Region

Table C-17 identifies the counties where the minimum geographic access standards were not met by **UHCCP** in a specific urbanicity or Behavioral Health Region for each applicable provider category, including pediatric specialists for appropriate categories. Results are presented separately for the general and pediatric populations as applicable.

Table C-17–Counties Not Meeting Geographic Access Standard by Provider Category for UHCCP

Provider Category	Counties Not Meeting Standard*
PCP	
Urban	Buffalo
High-Volume Specialists†**	
Cardiology	Cherry
Neurology	Boyd, Dundy, Sheridan
OB/GYN	Cherry, Sheridan
Oncology-Hematology	Cherry, Grant, Holt, Keya Paha, Rock, Sheridan
Pharmacy	
Urban	Adams, Buffalo, Dodge, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Clay, Custer, Thurston
Frontier	Grant, Hooker, Thomas
All Behavioral Health Inpatient and Residential Service Providers	
Urban	Scotts Bluff

Provider Category	Counties Not Meeting Standard*
Rural	Box Butte, Cheyenne, Dawes
Frontier	Banner, Kimball, Morrill, Sheridan, Sioux
Region 1	Banner, Box Butte, Cheyenne, Dawes, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Grant, Hooker, Thomas
Region 2	Grant, Hooker, Lincoln, Thomas
Region 4	Cherry
Hospitals**	
Hospitals	Adams, Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Burt, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Dixon, Frontier, Furnas, Garden, Garfield, Grant, Greeley, Harlan, Hayes, Hitchcock, Hooker, Johnson, Keith, Keya Paha, Lincoln, Logan, Loup, McPherson, Merrick, Nemaha, Nuckolls, Pawnee, Rock, Sheridan, Sherman, Sioux, Thomas, Thurston, Valley, Wayne, Wheeler
Optometry	
Urban	Adams, Buffalo, Lincoln
Rural	Cherry
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln, Madison, Platte
Rural	Dawes
Frontier	Sheridan
Dental	
Dentist, Rural	Cherry
Dental Specialists	
Oral Surgeon, Urban	Buffalo, Dawson, Gage, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Oral Surgeon, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Johnson, Keith, Knox, Merrick, Nance, Nemaha, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Thayer, Valley, York
Oral Surgeon, Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas, Wheeler

Provider Category	Counties Not Meeting Standard*
Orthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte
Orthodontist, Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Orthodontist, Frontier	Arthur, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Logan, Loup, McPherson, Perkins, Rock, Sheridan, Sherman, Thomas, Wheeler
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Periodontist, Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Pediadontist, Urban	Dakota, Dawson, Gage, Madison, Platte
Pediadontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Custer, Dawes, Dixon, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nance, Nemaha, Pawnee, Pierce, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne
Pediadontist, Frontier	Boyd, Brown, Dundy, Keya Paha, Rock, Sheridan

*Rows are only shown if at least one county did not meet the standard.
**The standard for this provider category does not differ by urbanicity.
†High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

Network Capacity Analysis

Table C-18 displays the statewide network capacity analysis results for **UHCCP** (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards. Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table C-18—UHCCP Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	2,014	1:57
High-Volume Specialists**		
Cardiology	230	1:496
Neurology	198	1:576
OB/GYN	248	1:160
Oncology-Hematology	124	1:919
Orthopedics	245	1:466
Pharmacy	430	1:265
All Behavioral Health Inpatient and Residential Service Providers	16	1:7,121
All Behavioral Health Outpatient Assessment and Treatment Providers	2,882	1:40
Hospitals	89	1:1,281
Optometry	354	1:322
Ophthalmology	105	1:1,086
Dental		
Dentist	304	1:375
Dental Specialists		
Oral Surgeon	12	1:9,495
Orthodontist	12	1:9,495
Periodontist	11	1:10,358
Pediadontist	36	1:1,653

Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.
* In calculating the ratios, all covered members were considered, except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older, and Pediadontists, where the member population was limited to members 18 years of age and under.
** High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

As an additional point of information in evaluating adequacy of provider networks, the average time and distance to the nearest two providers were calculated across members enrolled in each MCO and for each provider category. Although this analysis included all provider categories, it did not consider urbanicity. Table C-19 displays the statewide average travel times (in minutes) and travel distances (in miles) to the first- and second-nearest providers for **UHCCP** members.

Table C-19–UHCCP Members' Average Time and Distance to the Nearest First and Second Provider

Provider Category	First Nearest*	Second Nearest*
	Time (Min.) Dist. (Mi.)	Time (Min.) Dist. (Mi.)
PCP	2.1 / 1.8	2.3 / 1.9
High-Volume Specialists**		
Cardiology	9.7 / 8.3	11.4 / 9.8
Neurology	13.3 / 11.4	15.5 / 13.3
OB/GYN	8.8 / 7.5	10.2 / 8.9
Oncology-Hematology	10.6 / 9.0	13.2 / 11.3
Orthopedics	6.9 / 5.7	8.8 / 7.3
Pharmacy	2.9 / 2.5	5.4 / 4.6
All Behavioral Health Inpatient and Residential Service Providers	37.5 / 33.2	55.1 / 47.7
All Behavioral Health Outpatient Assessment and Treatment Providers	2.6 / 2.3	3.1 / 2.7
Hospitals	7.8 / 6.4	14.5 / 12.2
Optometry	4.2 / 3.6	5.1 / 4.3
Ophthalmology	9.5 / 8.0	11.7 / 10.0
Dental		
Dentist	5.6 / 4.8	7.9 / 6.8
Dental Specialists		
Oral Surgeon	50.7 / 44.0	76.7 / 66.8
Orthodontist	46.9 / 39.0	74.7 / 58.6
Periodontist	84.6 / 59.1	84.6 / 59.1
Pediadontist	19.7 / 16.9	23.5 / 19.5

*For some members, the nearest in-network providers may be out of state.
**High-Volume Specialists are those identified by DHHS for purposes of the time and distance analysis.

Recommendations Over the Past Year Based on Information Gathered During the Validation Process

Because this year's NAV activity methodology added a new scope of work in alignment with the 2023 release of the CMS EQR Protocol 4, the NAV audit activity was conducted for the first time in CY

2024–2025. HSAG has provided recommendations to **UHCCP** in the *Summary Assessment of Opportunities for Improvement and Recommendations* section, as necessary, based on the findings from the CY 2024–2025 NAV audit.

Strengths

UHCCP had processes to ensure the accuracy and completeness of member data through daily error reports, member count checks, quality reports, and S2S reports to ensure consistency of data within UMV and across systems. **[Access]**

UHCCP had processes to maintain provider data, including self-service tools available to providers as needed to support accurate and up-to-date provider information, and vendors to assist in validating provider data accuracy. **[Access]**

UHCCP had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has *High Confidence* in **UHCCP**'s ability to produce accurate results to support its own and the State's network adequacy monitoring efforts. **[Access]**

UHCCP met the State's time and distance standards for 11 of 39 provider category/urbanicity combinations, and at least 97 percent of **UHCCP** members had access within standards for all categories except dental specialists (29 of 39 provider categories). **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

UHCCP did not meet the time and distance standards for 28 of 39 provider/urbanicity combinations, although by less than 3 percentage points for 11 of these. Aside from the minimal shortfalls of 1 to 3 percentage points that might be expected as a result of routine fluctuations of providers, **UHCCP** had more serious gaps in member access to oral surgeons, orthodontists, periodontists, and pediadontists in rural counties. HSAG recommended that **UHCCP** maintain current levels of access to care and continue to address network gaps for the dental specialists. A list of the specific counties where **UHCCP** did not meet standards is provided in Table C-17.

Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)]

Table C-20 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2023–2024 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table C-20—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendation
Some **UHCCP** members may not have access within the standard to providers that specifically identify as having a pediatric specialty, especially with respect to behavioral health outpatient assessment and treatment

providers in rural and frontier areas, where the percentages of members with access is 79.0 percent and 58.1 percent, respectively. Looking at the results by Behavioral Health Region, **UHCCP** members may not have access to pediatric outpatient behavioral health specialists within the standard, particularly in Region 2, where only 44.8 percent have the required access. For these provider categories, the MCE should assess to what extent these results were due to a lack of providers available for contracting in the area, a lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons.

Response

Describe initiatives implemented based on recommendations:

1) **Access to pediatric Specialty Providers:** There is little ability to improve access to pediatric specialist across the State as the majority of pediatric specialists are located in urban settings and are a part of a Children's Medical Center. We are contracted with the 2 children's Medical Centers in the State. In addition, we have contracted with border state pediatric hospitals in Denver, and Sioux Falls South Dakota. We review access and availability reports on a quarterly basis and look to identify gaps and opportunities to fill those gaps with contracted providers.

2) **Access to behavioral health outpatient assessment and treatment providers**: We review opportunities to strengthen our behavioral health network routinely. We review gaps in geo access reports and compare to the MLTC Provider file to identify any opportunities for recruitment. Any gaps and opportunities to enhance our network is identified in our Network Development Plan. This plan is submitted annually to MLTC for network approval. Currently, our access percentage to behavioral health outpatient assessment and treatment providers for all members is 99.98 for rural and 97.83% for frontier counties. Since the beginning of 2024 we have added 405 unique providers to our behavioral health network. In addition, we have added 54 unique pediatric behavioral health providers to our network for 2024. Specifically in Region 2, our behavioral health outpatient assessment and treatment access percentage for all members is 99.4 % for urban, 100.0% for rural, 93.3%. We have added 5 unique pediatric behavioral health providers to our behavioral health network, specifically in Region 2, from the prior year. Lastly, we have expanded our network of providers participating in telehealth, giving members additional access points to pediatric behavioral health providers.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

We have enhanced our network by adding 405 unique providers to our behavioral health network compared to last year. We added 54 unique pediatric behavioral health providers to our network for 2024, and specifically in Region 2 we have added 5 unique pediatric behavioral health providers to our behavioral health network. we have expanded our network of providers participating in telehealth, giving members additional access points to pediatric behavioral health providers.

Identify any barriers to implementing initiatives:

Lack of pediatric behavioral health providers in rural and frontier counties.

Identify strategy for continued improvement or overcoming identified barriers:

We have expanded our network of providers participating in telehealth, giving members additional access points to pediatric behavioral health providers.

HSAG Assessment:

HSAG did not perform a separate analysis of pediatric behavioral health providers this year, and notes that **UHCCP**'s performance across all regions was close to or at the required 100 percent of members with access to providers, with the exception of Behavioral Health Region 1, the sparsely populated northwestern portion of the State. HSAG acknowledges **UHCCP**'s efforts to improve access to pediatric behavioral health providers in its network.

Appendix D. Information System Standards

Overview of the HEDIS Compliance Audit

Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. Organizations seeking NCQA accreditation or wishing to publicly report their HEDIS performance results undergo an NCQA HEDIS Compliance Audit through an NCQA-licensed organization. The audits are conducted in compliance with NCQA's *HEDIS MY 2023 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures*. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the organizations are reliable, valid, accurate, and can be compared to one another.

During the HEDIS audit, data management processes were reviewed using findings from the NCQA HEDIS Roadmap review, interviews with key staff members, and a review of queries and output files. Data extractions from systems used to house production files and generate reports were reviewed, including a review of data included in the samples for the selected measures. Based on validation findings, the LOs produced an initial written report identifying any perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement. The LOs also produced a FAR with updated text and findings based on comments concerning the initial report.

The FAR included information on the organization's information systems capabilities; each measure's reportable results; medical record review validation (MRRV) results; the results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and opportunities and recommendations for improvement of data completeness, data integrity, and health outcomes.

Information Systems Standards

Listed below are the IS Standards published in NCQA's *HEDIS MY 2023 Volume 5 HEDIS Compliance Audit: Standards, Policies, and Procedure.* IS standards assess the quality of an organization's information systems by measuring how the organization captures, manages, integrates, and reports medical, member, practitioner, and vendor data. IS standards specify the minimum requirements for information systems and criteria for data management and reporting.

IS R—Data Management and Reporting (formerly IS 6.0 and 7.0)

IS R1—The organization's data management enables measurement.

- Data standards, information systems, and processes for transferring and integrating source files are fully documented.

- File layouts, data models, and data dictionaries used by the organization for data management are complete.
- Data source identifiers are clear and documented.

IS R2—Data extraction and loads are complete and accurate.

- Transfer protocols capture all data elements for measurement.
- Referential integrity is maintained during transmission.
- Organization ensures extraction, and loads do not result in unintended data modification, deletion, or generation.

IS R3—Data transformation and integration is accurate and valid.

- File conversions maintain referential and data integrity.
- Information tagging to enable measurement is accurate and valid.
- Modifications, normalizations, and mappings to conform with data models, coding systems, and measure requirements are documented and valid.
- Processing and transformation do not result in inappropriate data modification, deletion, or generation.

IS R4—Data quality and governance are components of the organization's data management.

- The organization's design, implementation, and improvements to its data management approach supports complete, valid, accurate, and reliable measurement.
- Internal governance structures include responsibilities for data quality and integrity.

IS R5—Oversight and controls ensure correct implementation of measure reporting software.

- Reporting protocols and arrangements with vendors allow inspection, auditing, correction, and resubmission of data.
- Use of certified measure logic is confirmed.
- Reports demonstrate that data and results from implementing measure reporting software are complete and accurate.

IS C—Clinical and Care Delivery Data (formerly IS 5.0)

IS C1—Data capture is complete.

- Electronic standards, formats, and protocols ensure capture of all data elements.
- Data entry processors enter all required data elements.
- Organization ensures data are not modified, deleted, or generated during capture.

- Reports indicate data completeness.

IS C2—Data conform with industry standards.

- Organization uses industry standard data models, coding systems, and layouts.
- Nonstandard data models, coding systems, and layouts are fully documented.
- Data modification, normalization, and mapping are appropriate and do not inappropriately impact measures.
- Processing and transformation do not inappropriately modify, delete, or generate data.

IS C3—Transaction file data are accurate.

- Organization systems and protocols include edit checks and controls to confirm accuracy.
- Comparison of a sample of transmitted files with source documents ensures data are accurate.
- Reports indicate data source impact on results.

IS C4—Organization confirms ingested data meet expectations for data quality.

- Organization maintains standards and requirements for inbound data to ensure data quality.
- Internal systems and processes identify data quality issues.
- Controls are in place to evaluate and monitor quality of data used by the organization.

IS M—Medical Record Review Processes (formerly IS 4.0)

IS M1—Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).

- Forms or tools used for MRR—including samples of completed forms, policies, procedures, and instructions for completing the forms—ensure:
  - All fields relevant to measure reporting are included.
  - Forms guide the reviewer to the medical record data elements.
- Electronic file formats and protocols ensure all data fields are captured for each measure.
- Policies, procedures, and program code for files used to transfer administrative data to the MRR tools are complete and available.
- Policies and procedures for submission and transmission of electronic information show:
  - The organization effectively monitors the quality and accuracy of its electronic submissions.
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions, and sign-offs.

IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed.

- Policies and procedures—including chase logic and chart retrieval—ensure accuracy and completeness and verify the organization has mechanisms for transferring information to the appropriate location within the organization.
- Interrater reliability standards and results ensure MRR is accurate and complete.

IS M3—Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.

- Standard monitoring reports for all data entry operations personnel verify the organization effectively monitors the quality, accuracy, timeliness, and productivity of its entry processes.
- Flowcharts and timelines describe MRR processing from all sources.
- Data entry processors enter all required data elements for each measure.
- Data entry policies and procedures ensure accuracy and completeness.
- MRR data entry screens have:
  - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claims/encounter and practitioner file, code ranges, and practitioner services by specialty.
  - All necessary data fields for each measure.
- Data transaction files are accurate, including:
  - Comparison of a sample of data entry files with source documents to ensure that all data are entered, and that data are not changed or deleted during processing.
  - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted, and that data are not changed or deleted during processing.
- The convenience sample, if applicable, ensures that the MRR process begins accurately.
- MRRV verifies that the MRR process worked as planned.

IS M4—The organization continually assesses data completeness and takes steps to improve performance.

- Tracking documents indicate the progress of the MRR and the number of numerator-compliant members and exclusions.
- Policies and procedures and performance standards require:
  - Complete submission and entry of medical record data.
  - Transmissions to be properly controlled by logs, record count verification, redundancy checking receipts, retransmissions, and sign-offs.

IS M5—The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for measure reporting and provide inspection and auditing of data; correction and resubmission of data, and backlog control standards and procedures; and enforce quality standards.
- Studies and reports show that:
  - Data from vendors are complete and accurate.
  - No data are lost or modified during transfer.

IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)

IS A1—Data conform with industry standards and measure requirements.

- Standard layouts and forms are used.
- Medical service transaction files include industry standard codes (e.g., International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM]; Healthcare Common Procedure Coding System [HCPCS]).
- Nonstandard layouts, forms, and codes are documented, and mapping is appropriate.
- Mapping and normalization of provider specialty comply with measure requirements.

IS A2—Data are complete and accurate.

- Electronic standards, formats, and protocols ensure capture of all data elements, required codes, and characters for the appropriate system.
- Organization ensures data are not modified, deleted, or generated during capture.
- Organization ensures data processing, transformation, or reconciliation produces the intended result.
- Reports indicate data completeness and impact on reporting.

IS A3—Membership information system enables measurement.

- Organization's membership system can accommodate:
  - Changes to product line.
  - Changes to product.
  - Methods for defining coverage start and end.
  - Methods for identifying dual enrollment.
  - Multiple changes to membership status.
- Processing and transformation of membership information does not inappropriately modify, delete, or generate data.

Appendix E. Network Adequacy Standards

DHHS quantitative standards for network adequacy are contained in its managed care contracts and listed in regular provider network reports submitted by the MCOs via templates provided by DHHS. DHHS provided HSAG with specifications for these reports as well as copies of communications regarding the intent behind the standards that occurred between DHHS and the MCOs. For the MCOs, network adequacy standards include maximum travel time or distance to providers, minimum provider-to-member ratios, minimum network capacity and timely access standards as described below. For the DO, there are only time or distance and timely access standards.

MCO Network Adequacy Standards

Time or Distance

MCOs are required to submit provider network reports annually and on an ad hoc basis using report templates provided by DHHS. Table E-1 details the physical health and behavioral health geographic access standards for each provider category and county urbanicity as outlined in Attachment 14: Access Standards 2024.[25]

Table E-1—Time and Distance Standards by Provider Category and County Urbanicity

Provider Category	County Urbanicity[1]	Geographic Access Standard
Physical Health and Behavioral Health Geographic Access Standards		
PCPs	Urban	2 providers within 30 miles
	Rural	1 provider within 45 miles
	Frontier	1 provider within 60 miles
High-volume specialists: Cardiology, Neurology, Hematology/Oncology, Obstetrics/Gynecology, and Orthopedics	All counties	1 provider within 90 miles
Pharmacy	Urban	90 percent of members within 5 miles of one provider
	Rural	70 percent of members within 15 miles of one provider
	Frontier	70 percent of members within 60 miles of one provider

[25] Attachment 14: Access Standards 2024—Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 13, 2025.

Provider Category	County Urbanicity[1]	Geographic Access Standard
Behavioral health inpatient and residential service providers	Rural and Frontier	1 provider within 240 miles[2]
Behavioral health outpatient assessment and treatment provider	Urban	2 providers within 30 miles
	Rural	2 providers within 45 miles[3]
	Frontier	2 providers within 60 miles[3]
Hospitals	All counties	1 hospital transport time not to exceed 30 minutes.[4]
General optometrists	Urban	1 provider within 30 minutes or less transport time
	Rural	1 provider within 60 minutes or less transport time
	Frontier	1 provider within 90 minutes or less transport time
Ophthalmologists	Urban	1 provider within 30 minutes or less transport time
	Rural	1 provider within 90 minutes or less transport time
	Frontier	1 provider within 90 minutes or less transport time
Dental Geographic Access Standards		
General Dentist	Urban	2 providers within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Oral Surgeon	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members
Orthodontist	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members

Provider Category	County Urbanicity[1]	Geographic Access Standard
Periodontist	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members
Endodontist	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members
Prosthodontist	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members
Pediadontist	Urban	1 provider within 45 miles of 85 percent of members
	Rural	1 provider within 60 miles of 75 percent of members
	Frontier	1 provider within 100 miles of 75 percent of members

[1] Urban, rural, and frontier county designations are detailed in Attachment 2: Nebraska Counties Classified by Urban/Rural/Frontier Status. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%202%20-%20Nebraska%20Counties%20Classified%20by%20Urban,%20Rural,%20Frontier%20Status.pdf. Accessed on: Feb 13, 2025.

[2] Attachment 14 requires "sufficient locations to allow members to travel to one provider and return home within a single day," which has been defined by DHHS as at least 1 provider within 240 miles. Access Standards 2024—Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 13, 2025.

[3] If the standard cannot be met because of a lack of behavioral health providers in particular counties, DHHS requires that the MCO utilize telehealth options.

[4] The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed thirty (30) minutes, except in rural and frontier 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 Division of Medicaid & Long-Term Care (MLTC) on the basis of community standards.

Appointment Availability Access Standards

DHHS has set timely access standards for MCOs and requires that the MCOs conduct annual surveys and activities to assess whether members have access to care within reasonable time limits. Table E-2 presents Physical Health Appointment Availability Access Standards as outlined in Attachment 14: Access Standards 2024.[26]

Table E-2—Physical Health Appointment Availability Access Standards

Appointment Category	Access Standards	
Appointment Availability Access Standards		
Emergency Services	Physical Health	Immediately available 24 hours per day, 7 days per week.
	Behavioral Health	Immediately available 24 hours per day, 7 days per week. Referred to services within one hour generally, 2 hours in designated rural areas.
Urgent Care	Available same day and provided by the PCP or as arranged by the MCO.	
Non-Urgent Sick Care	Available within 48 hours or sooner, if the member's medical condition deteriorates to an urgent or emergent situation.	
Family Planning Services	Available within 7 calendar days.	
Non-Urgent Preventive Care	Available within 4 weeks.	
PCPs	Physicians who have a 1 physician practice must have office hours of at least 20 hours per week. Practices with 2 or more physicians must have office hours of at least 30 hours per week.	
High-Volume Specialty Care	Routine appointments must be available no later than 30 calendar days after referral. Consultation must be available no later than 1 month after referral or as clinically indicated.	
Laboratory & X-Ray Services	Available, after ordered, no later than 3 weeks for routine appointments and 24 hours (or as clinically indicated) for urgent care.	
Maternity Care Services	First Trimester	Available no later than 14 calendar days after request.
	Second Trimester	Available no later than 7 calendar days after request.
	Third Trimester	Available no later than 3 calendar days after request.
	High Risk	Available no later than 3 calendar days after identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

[26] Attachment 14: Access Standards 2024—Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 13, 2025.

Table E-3 presents Dental Health Appointment Availability Access Standards as outlined in Attachment 14: Access Standards 2024.[27]

Table E-3—Dental Appointment Availability Access Standards

Appointment Category	Access Standards
Appointment Availability Access Standards	
Urgent Care	Available no later than 24 hours from request.[1]
Routine or Preventative Care	Available no later than 6 weeks of request of service.
Scheduled Appointment Wait Times	No longer than 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.

[1] Urgent care may be provided directly by the primary care dentist or directed by the MCO through other arrangements.

[27] Attachment 14: Access Standards 2024—Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 13, 2025.