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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2025–2026 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.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Report Purpose and Overview

Since April 2021, Health Services Advisory Group, Inc. (HSAG), has served as the external quality review organization (EQRO) for the Nebraska Department of Health and Human Services (DHHS). As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364, DHHS contracted with HSAG to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care organizations (MCOs). The CFR requires that states contract with an EQRO to conduct an annual evaluation of managed care entities (MCEs) that serve Medicaid members to determine each MCO's compliance with federal quality assessment and performance improvement (QAPI) standards.

Heritage Health Program

Heritage Health, Nebraska's Medicaid and Children's Health Insurance Program (CHIP) managed care program, is administered by the DHHS Division of Medicaid & Long-Term Care (MLTC). The current MCE contracts are full-risk, capitated managed care contracts. Managed care to administer the Medicaid and CHIP programs in Nebraska was developed to improve the health and wellness of Nebraska's Medicaid and CHIP members by increasing access to comprehensive health care services in a cost-effective manner. Heritage Health combines Nebraska Medicaid's physical health, behavioral health, dental, and pharmacy programs into a single comprehensive and coordinated program for the State's Medicaid and CHIP members. To receive their health care benefits, Heritage Health members enroll in one of three health plans which serve all Medicaid and CHIP members statewide under 1915(b) authority: **Molina Healthcare of Nebraska** (**MHN**), **Nebraska Total Care** (**NTC**), and **United Healthcare Community Plan** (**UHCCP**).

During calendar year (CY) 2025, DHHS used the exemption option allowed under 42 CFR §438.362 to exempt **MHN**'s, **NTC**'s, and **UHCCP**'s Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) plans from EQR. The beginning date of the current exemption period is January 1, 2026, and ends December 31, 2026.

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 December 2025.

Table 1-1—Heritage Health MCOs

MCO	Services Provided	NCQA Accreditation Status	Total Members
MHN	Physical and behavioral health care, pharmacy services, and dental services	Medicaid HMO Accreditation 2024 • Interim • Expires 11/24/2025 Medicaid HMO Accreditation 2025 • Accredited • Expires 07/22/2028	113,537
NTC	Physical and behavioral health care, pharmacy services, and dental services	Medicaid HMO Accreditation • Accredited • Expires 11/04/2028 Medicaid HMO Health Equity • Accredited • Expires 11/30/2025	110,020
UHCCP	Physical and behavioral health care, pharmacy services, and dental services	Medicaid HMO Accreditation • Accredited • Expires 07/19/2026 Medicaid HMO Health Equity • Accredited • Expires 12/01/2025	108,802

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 (QI), 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 QI. 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 1-2, 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 1-2—Aims, 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.
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.

Aim	Goal	Objective
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.
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 aims, 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.

Aggregating and Analyzing Statewide Data

42 CFR §438.364(a)(1) requires this technical report to include a description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the health plans. HSAG follows a four-step process to aggregate and analyze data collected from all external quality review (EQR) activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each health plan, as well as the program overall.

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.

Detailed information about each activity's methodology is provided in Section 3 of this report. For a comprehensive discussion of the strengths, opportunities for improvement, conclusions, and recommendations, please refer to the results of each activity in the MCO-specific analyses in appendices A–C.

Please note, program-level and MCO-specific "strengths" are identified throughout this report in alignment with the Centers for Medicare & Medicaid Services (CMS) guidance. However, rather than identifying "weaknesses," HSAG, in advisement from DHHS, has designated "opportunities for improvement" throughout the report, which include areas wherein program or health plan performance was identified as needing improvement and recommendations were made to address performance.

Domains

CMS has identified the domains of quality, timeliness, and access as keys to evaluating plan performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the plans in each of these domains.

Quality	Timeliness	Access
as it pertains to EQR, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (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]	as it pertains to EQR, is described by the NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. 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).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans (MCPs) 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.[1]

[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] National Committee for Quality Assurance (NCQA). *2013 Standards and Guidelines for MBHOs and MCOs.*

Scope of EQR

HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted in alignment with the associated EQR protocols, adhering to specific methodologies and data requirements developed by CMS.[1] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans with which they contract for services and help health plans improve their performance with respect to the quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2026.

state efforts to purchase high-value care and to achieve higher-performing health care delivery systems for Medicaid and CHIP members. For this technical report, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 below, as well as the additional activities described in Section 3, to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCO.

Table 1-3—EQR Mandatory Activities

Activity	Description	CMS Protocol
Mandatory Activities		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCO used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects (CMS EQR Protocol 1)
Performance Measure Validation (PMV)	This activity determines the extent to which performance measures calculated by the MCOs followed specifications required by NCQA.	**Protocol 2.** Validation of Performance Measures (CMS EQR Protocol 2)
Assessment of Compliance With Medicaid Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations (CMS EQR Protocol 3)
Network Adequacy Validation (NAV)	This activity includes validating data to determine whether the network standards, as defined by the state, were met. Additionally, a network capacity analysis is conducted.	**Protocol 4.** Validation of Network Adequacy (CMS EQR Protocol 4)
Optional Activities		
Network Adequacy Dashboard	This activity provides dashboard and saturation analysis components that function primarily as visualization tools that operationalize previously documented NAV results.	**Protocol 9.** Conducting Focus Studies of Health Care Quality (CMS EQR Protocol 9)
Provider Directory Validation (PDV) and Secret Shopper	This activity assesses the accuracy of the managed care network information using the MCOs' provider data files, the MCOs' online provider directories, and secret shopper calls to sampled provider locations. Additionally, the secret shopper survey assesses appointment availability and compliance with DHHS' wait time standards.	**Protocol 9.** Conducting Focus Studies of Health Care Quality (CMS EQR Protocol 9)

Heritage Health Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the most current 12-month period to comprehensively assess the MCOs' performance in providing quality, timely, and accessible health care services to Medicaid and CHIP members. For each MCO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCO's performance, which can be found in appendices A–C of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations. Table 1-4 highlights substantive findings, and Table 1-5 identifies actionable state-specific recommendations, when applicable, for DHHS to further promote its Quality Strategy goals and recommendations.

Table 1-4—Substantive Findings

Program Strengths	Domain(s)[2]
Quality Strategy Aim: Improve the Member Experience of Care	
No program strengths were identified for this aim.	
Quality Strategy Aim: Improve the Provider Experience of Care	
All three MCOs met the required time and distance standards for High-Volume Obstetrics/Gynecology (OB/GYN), High-Volume Orthopedics, Pharmacy, All Behavioral Health Inpatient and Residential Services Providers, and Pediadontists across all urbanicities.	
All MCOs had sufficient policies and procedures in place to ensure the use of sound methods for assessing managed care network adequacy and demonstrated defined processes to support accurate and up-to-date provider data, with HSAG expressing High Confidence in each MCO's ability to produce accurate results to support State and plan-level network adequacy monitoring.	
Quality Strategy Aim: Improve the Health of Populations	
All MCOs received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP and the *Health Risk Screener Completion in Pregnant Members* PIP.	
The Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 6 to 17 Years, 30-Day Follow-Up—Ages 6 to 17 Years measure indicators were a strength for all MCOs. All MCOs ranked at or above the Quality Compass (QC) national Medicaid HEDIS measurement year (MY) 2024 50th percentile benchmark on these indicators, demonstrating that the 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 rehospitalization.	

[2] = Quality, = Timeliness, = Access

Program Strengths	Domain(s)[2]
The *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years* measure indicator and the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years* measure indicator was a strength for all MCOs. All MCOs ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators, demonstrating that the MCOs effectively prevented or minimized the prescribing of antibiotics to treat adult members diagnosed with a URI and child members diagnosed with bronchitis or bronchiolitis.	
The *Use of Opioids at High Dosage (HDO)* measure was a strength for all MCOs. All MCOs were ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure, demonstrating that the MCOs effectively prevented or minimized the prescribing of opioids at high dosage.	
The *Initiation and Engagement of SUD Treatment (IET)—Engagement of SUD Treatment—Total —Ages 13 to 17 Years* measure indicator was a strength for all MCOs. All MCOs ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator, demonstrating that the MCOs effectively engaged young members with a new SUD episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment.	
Quality Strategy Aim: Reduce the Per Capita Cost of Health Care	
No program strengths were identified for this aim.	
Other Program Effectiveness Areas	
All MCOs used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for all PIPs.	
Other Program Effectiveness Areas	
All MCOs submitted a large body of evidence to substantiate compliance with each standard reviewed in the compliance review. 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.	
All MCOs achieved full compliance with the QAPI standard, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; MLTC-approved PIPs; and timely reporting to MLTC.	

Program Opportunities for Improvement	Domain(s)
Quality Strategy Aim: Improve the Member Experience of Care	
No program opportunities were identified for this aim.	
Quality Strategy Aim: Improve the Provider Experience of Care	
All three MCOs failed to meet some time and distance standards for High-Volume Oncology-Hematology, All Behavioral Health Outpatient Assessment and Treatment Providers, Hospitals, Optometry, Ophthalmology, Dentists, Oral Surgeons, Orthodontists, Periodontists, Endodontists, and Prosthodontists.	
Quality Strategy Aim: Improve the Health of Populations	
All three MCOs ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile—Total, Counseling for Nutrition—Total, Counseling for Physical Activity—Total* measure indicators, demonstrating the MCOs did not screen young members for obesity and provide nutrition counseling as recommended.	
All three MCOs ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years and Total* measure indicators, demonstrating the MCOs did not conduct routine chlamydia screenings as recommended.	
All three MCOs ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Initiation of SUD Treatment—Total—Ages 18 to 64 Years, and Initiation of SUD Treatment—Total—Total* measure indicators, demonstrating the MCOs failed to initiate timely treatment for members with new SUD episodes.	
Quality Strategy Aim: Reduce the Per Capita Cost of Health Care	
No program opportunities were identified for this aim.	
Other Program Effectiveness Areas	
Across all MCOs, compliance gaps were identified related to the inclusion and implementation of required federal regulations and MLTC contract provisions in written policies and procedures, indicating a need to ensure all applicable requirements are fully incorporated and operationalized.	

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Table 1-5—Recommendations

Domain	Program Recommendations	Quality Strategy Aim and Goal
	For the provider categories for which MCOs did not meet the time and distance standards, HSAG recommends that the MCOs assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify providers in the data using the standard definitions, or other reasons. If the inability to meet the time and distance standard is due to data concerns, the MCOs should ensure all providers are appropriately identified in future data submissions.	***Aim:*** Improve the Provider Experience of Care **Goal 1:** Expand access to high-quality services to meet the needs of diverse clients
	HSAG recommends that all MCOs 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.	***Aim:*** Improve the Health of Populations **Goal 1:** Promote wellness and prevention
	HSAG recommends that all MCOs encourage its providers to conduct regular follow-ups with adolescent and adult female members, through various modes of communication, to ensure members return for chlamydia screenings.	***Aim:*** Improve the Health of Populations **Goal 1:** Promote wellness and prevention
	HSAG recommends that all MCOs work with its providers to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment.	***Aim:*** Improve the Health of Populations **Goal 1:** Promote wellness and prevention
	The MCOs should review and update their policies, procedures, and operational processes to ensure that all applicable federal Medicaid managed care regulations and MLTC contract requirements are fully incorporated and consistently implemented.	***Aim:*** Other Program Effectiveness Areas **Goal 1:** Build transparent and trusting stakeholder relationships

2. Comparative Statewide Results

Mandatory EQR Activities

Validation of Performance Improvement Projects

Results

Table 2-1 summarizes key PIP validation milestones that occurred from April 2025 through October 2025.

Table 2-1—CY 2025-2026 MCO PIP Activities

PIP Activities and Milestones	Dates
The MCOs submitted initial PIP submissions to HSAG for validation	April 25, 2025
HSAG provided initial PIP Validation Tools to the MCOs	June 2, 2025
The MCOs submitted final PIP submissions to HSAG for validation	June 23, 2025
HSAG provided final PIP Validation Tools to the MCOs	August 4, 2025
HSAG delivered final PIP reports to the MCOs	October 27, 2025

Table 2-2 summarizes the CY 2025–2026 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.

Table 2-2—Statewide PIP Results for MCOs

MCO	PIP Topic	Clinical or Nonclinical Topic	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
MHN	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	Clinical	*High Confidence*	*Not Assessed*[1]
MHN	*Health Risk Screener Completion in Pregnant Members*	Nonclinical	*High Confidence*	*Not Assessed*[1]
NTC	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	Clinical	*High Confidence*	*Not Assessed*[1]

MCO	PIP Topic	Clinical or Nonclinical Topic	Validation Rating 1 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP	Validation Rating 2 Overall Confidence That the PIP Achieved Significant Improvement
NTC	*Health Risk Screener Completion in Pregnant Members*	Nonclinical	*High Confidence*	*Not Assessed*[1]
UHCCP	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	Clinical	*High Confidence*	*Not Assessed*[1]
UHCCP	*Health Risk Screener Completion in Pregnant Members*	Nonclinical	*High Confidence*	*Not Assessed*[1]

[1] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were uniformly captured, reported, and presented, HSAG evaluated each MCO's information system (IS) capabilities for accurate HEDIS reporting. HSAG reviewed the IS capabilities assessments of the MCOs, which were conducted by licensed organizations (LOs) and included in the final audit reports (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 2024 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 MCOs' key findings for each IS standard as noted in their FAR. A more in-depth explanation of the NCQA IS standards is provided in Appendix D of this report.

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

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 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. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• All MCOs were compliant with IS Standard R for data management and reporting. • The MCOs had procedures in place so that all data elements required for HEDIS reporting were adequately captured. • The MCOs had policies and procedures in place for validation of data extraction, transformation, and integration. • The MCOs were compliant with the standard for oversight and controls that ensure correct implementation of measures reporting software. • The MCOs had practices in places to promote protection and resiliency of systems and data. • Sufficient 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.	• All MCOs were compliant with IS Standard C for clinical care delivery data. • The MCOs had procedures in place so that all data elements required for HEDIS reporting were completely captured. • The MCOs had policies and procedures in place for submitted data that conform with industry standards. • Sufficient 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.	• All MCOs were compliant with IS Standard M for medical record review processes. • Data collection tools used by the MCOs were 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 2024 FARs Review
• 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.	• All MCOs were compliant with IS Standard A for administrative data. • The MCOs appropriately validated that data conform with industry standards and measure requirements. • The MCOs verified their membership information systems to ensure that they appropriately enable measurement. • Sufficient validation processes were in place to ensure that data are accurate and complete.

Results for Performance Measures

Table 2-4—Nebraska MCO Performance—CMS Adult and Child Core Set MY 2024

CMS Core Set Measures	MHN	NTC	UHCCP
CMS Adult Core Measures			
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)			
Use of Pharmacotherapy for Opioid Use Disorder—Total (Rate 1)	X	57.49%	39.17%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)			
*Ages 18 to 64**	X	1.89%	4.20%
*Age 65 and Older**	X	1.69%	3.75%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)			
Ages 18 to 64	X	1.63%	1.62%
Age 65 and Older	X	1.17%	4.33%
Concurrent use of Opioids and Benzodiazepines (COB-AD)			
*Ages 18 to 64**	X	20.42%	23.07%
*Age 65 and Older**	X	8.57%	19.50%

CMS Core Set Measures	MHN	NTC	UHCCP
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	X	9.64%	8.57%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	X	47.06%	43.92%
Long-Acting Reversible Method of Contraception (LARC)—Within 3 Days of Delivery	X	0.73%	0.67%
LARC—Within 90 Days of Delivery	X	16.31%	17.13%
Contraceptive Care—All Women Ages 21 to 44 (CCW-AD)			
Most or Moderately Effective Contraception	X	27.59%	27.40%
LARC	X	6.73%	6.34%
CMS Child Core Measures Set			
Developmental Screening in the First Three Years of Life (DEV-CH)			
Children Who Turned 1 Year	X	28.43%	24.58%
Children Who Turned 2 Years	X	37.98%	36.31%
Children Who Turned 3 Years	X	33.83%	29.50%
Total	X	33.28%	30.03%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)			
Ages 12 to 17	X	1.88%	1.78%
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	X	1.04%	2.34%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	X	54.17%	45.03%
LARC—Within 3 Days of Delivery	X	0.00%	0.58%
LARC—Within 90 Days of Delivery	X	25.52%	18.13%
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)			
Most or Moderately Effective Method of Contraception	X	28.05%	25.32%
LARC	X	5.49%	4.22%
Oral Evaluation, Dental Services (OEV-CH)			
Age Less Than 3	X	26.14%	27.41%
Ages 3 to 5	X	57.03%	59.65%
Ages 6 to 14	X	58.22%	62.19%

CMS Core Set Measures	MHN	NTC	UHCCP
Ages 15 to 20	X	35.28%	39.63%
Total	X	48.03%	51.57%
Sealant Receipt on Permanent First Molars (SFM-CH)			
At Least One Sealant	X	7.10%	3.85%
All Four Molars Sealed	X	3.85%	2.04%
Prevention: Topical Fluoride for Children (TFL-CH)			
Dental or Oral Health Services—Ages 1 to 20	X	27.19%	29.20%
Dental Services—Ages 1 to 20	X	24.63%	27.91%
Oral Health Services—Ages 1 to 20	X	0.32%	0.42%

* For this indicator, a lower rate indicates better performance
X indicates that **MHN**'s Core Set measure rates were not independently validated and are not presented in this report. **NTC** and **UHCCP** confirmed that their Core Set measure rates were validated by their NCQA-licensed organizations.

Table 2-5—Nebraska MCO Performance and Statewide Weighted Averages—HEDIS MY 2024

HEDIS Measures	MHN	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	48.18% ★	75.18% ★	75.18% ★	67.67%
Counseling for Nutrition—Total	38.20% ★	63.75% ★	69.34% ★★	58.73%
Counseling for Physical Activity—Total	38.20% ★	60.58% ★	66.42% ★★	56.53%
Childhood Immunization Status (CIS)				
Combination 3	59.82% ★	73.72% ★★★★	77.37% ★★★★★	74.67%
Combination 7	51.96% ★	67.88% ★★★★★	70.56% ★★★★★	68.25%
Combination 10	25.38% ★★	41.36% ★★★★★	43.55% ★★★★★	41.50%
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, tetanus, diphtheria toxoids and acellular pertussis [Tdap])	84.67% ★★★	81.02% ★★	79.81% ★★	80.58%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	31.42% ★★	34.55% ★★	35.04% ★★	34.65%
Lead Screening in Children (LSC)				
Lead Screening in Children	53.78% ★	71.78% ★★★	79.32% ★★★★	74.33%
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	38.20% ★	66.67% ★★★★	61.07% ★★★	56.26%
Chlamydia Screening in Women (CHL)				
Ages 16 to 20 Years	32.88% ★	33.92% ★	32.25% ★	33.02%
Ages 21 to 24 Years	44.47% ★	47.86% ★	38.71% ★	43.51%
Total	37.80% ★	39.84% ★	35.03% ★	37.50%
Effectiveness of Care Domain: Respiratory Conditions				
Appropriate Testing for Pharyngitis (CWP)				
Ages 3 to 17 Years	84.63% ★★	82.11% ★★	82.54% ★★	82.69%
Ages 18 to 64 Years	79.05% ★★★	76.56% ★★	74.37% ★★	75.97%
Ages 65 Years and Older	NA	NA	NA	60.53%
Total	83.34% ★★	80.76% ★★	80.50% ★★	81.04%
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	66.29% ★★	68.10% ★★	74.39% ★★★	70.93%
Bronchodilator	75.84% ★	78.57% ★	84.63% ★★★	81.08%
Asthma Medication Ratio (AMR)				
Ages 5 to 11 Years	NA	70.20% ★★★	71.46% ★★★	70.93%
Ages 12 to 18 Years	NA	73.83% ★★★★	72.38% ★★★	72.97%
Ages 19 to 50 Years	NA	69.47% ★★★★	69.03% ★★★★	69.21%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Ages 51 to 64 Years	NA	75.00% ★★★★	72.29% ★★★★	73.11%
Total	NA	71.26% ★★★★	70.84% ★★★★	71.01%
Effectiveness of Care Domain: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure (<140/90 mm Hg)	17.27% ★	73.24% ★★★★	74.45% ★★★★	61.74%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	60.34%
Effectiveness of Care Domain: Diabetes				
Glycemic Status Assessment for Patients With Diabetes (GSD)				
Glycemic Status <8.0%	22.14% ★	62.04% ★★★	67.64% ★★★★★	55.89%
*Glycemic Status >9.0%**	73.24% ★	28.71% ★★★	23.11% ★★★★★	35.89%
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure <140/90 mm Hg	10.26% ★	76.64% ★★★★	78.59% ★★★★	62.73%
Eye Exam for Patients With Diabetes (EED)				
Eye Exam	47.93% ★	63.02% ★★★★	68.86% ★★★★★	62.51%
Effectiveness of Care Domain: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	62.24% ★★	60.10% ★★	67.64% ★★★	64.14%
Effective Continuation Phase Treatment	48.95% ★★★	42.24% ★★	48.63% ★★★	45.99%
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Ages 6 to 17 Years	52.36% ★★★	67.83% ★★★★★	57.21% ★★★	59.78%
30-Day Follow-Up—Ages 6 to 17 Years	76.01% ★★★	84.54% ★★★★★	80.35% ★★★★	80.71%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
7-Day Follow-Up—Ages 18 to 64 Years	33.93% ★★	43.62% ★★★★	43.38% ★★★	40.39%
30-Day Follow-Up—Ages 18 to 64 Years	53.08% ★★	60.02% ★★★	64.49% ★★★	59.43%
7-Day Follow-Up—Ages 65 Years and Older	NA	NA	50.00% ★★★★	49.09%
30-Day Follow-Up—Ages 65 Years and Older	NA	NA	63.04% ★★★	61.82%
7-Day Follow-Up—Total	37.99% ★★	50.57% ★★★★	46.92% ★★★	45.33%
30-Day Follow-Up—Total	58.09% ★★	67.05% ★★★	68.30% ★★★	64.77%
Follow-Up After ED Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	34.63% ★★	40.94% ★★	42.66% ★★★	39.82%
30-Day Follow-Up—Total	55.12% ★★	57.95% ★★★	62.71% ★★★	59.02%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7-Day Follow-Up—Total	27.31% ★★	30.95% ★★	28.86% ★★	28.99%
30-Day Follow-Up—Total	45.51% ★★	50.34% ★★	47.54% ★★	47.73%
Follow-Up After ED Visit for Substance Use (FUA)				
7 -Day Follow-Up—Total	23.85% ★★	28.42% ★★★	26.48% ★★	26.23%
30-Day Follow-Up—Total	38.22% ★★	39.82% ★★★	43.15% ★★★	40.35%
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	81.23% ★★	83.95% ★★★	83.74% ★★★	83.24%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	59.14% ★	71.59% ★★	72.06% ★★	70.28%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	67.65% ★	68.63%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.83% ★★	66.67% ★★	78.33% ★★★★★	72.04%
Effectiveness of Care Domain: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI)				
Ages 3 Months to 17 Years	90.14% ★★	89.23% ★	89.63% ★	89.54%
Ages 18 to 64 Years	80.88% ★★★	80.42% ★★★	81.84% ★★★	81.13%
Ages 65 Years and Older	NA	NA	74.17% ★★★	74.83%
Total	88.21% ★★	87.21% ★★	87.66% ★★	87.55%
Use of Imaging Studies for Low Back Pain (LBP)				
Ages 18 to 64 Years	64.78% ★	70.48% ★★★	72.15% ★★★	70.33%
Ages 65 to 75 Years	NA	NA	72.37% ★★★	69.61%
Total	64.96% ★	70.32% ★★★	72.16% ★★★	70.31%
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage (Average Morphine Milligram Equivalent Dose [MME] ≥ 90)**	1.36% ★★★	1.81% ★★★	3.68% ★★★	2.68%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
Ages 3 Months to 17 Years	80.58% ★★★★	71.66% ★★★	73.32% ★★★	73.47%
Ages 18 to 64 Years	40.14% ★★	34.77% ★	34.56% ★	35.24%
Ages 65 Years and Older	NA	NA	30.77% ★★	29.41%
Total	67.32% ★★★	58.90% ★★	58.99% ★★	59.91%

HEDIS Measures	MHN	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	30.59% ★	34.26% ★	32.94% ★	33.24%
Engagement of SUD Treatment—Total — Ages 13 to 17 Years	15.29% ★★★	20.37% ★★★★★	12.83% ★★★	16.36%
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	39.66% ★	36.94% ★	38.41% ★	37.99%
Engagement of SUD Treatment—Total — Ages 18 to 64 Years	12.41% ★★	11.48% ★★	10.70% ★★	11.24%
Initiation of SUD Treatment—Total—Ages 65 Years and Older	NA	NA	42.62% ★★	43.33%
Engagement of SUD Treatment—Total — Ages 65 Years and Older	NA	NA	3.83% ★	4.29%
Initiation of SUD Treatment—Total—Total	38.83% ★	36.76% ★	38.10% ★	37.66%
Engagement of SUD Treatment—Total — Total	12.73% ★★	12.39% ★★	10.55% ★★	11.55%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	85.64% ★★	87.83% ★★★	90.75% ★★★★	88.35%
Postpartum Care	72.51% ★	83.21% ★★★	88.81% ★★★★★	82.49%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Ages 1 to 11 Years	53.85% ★★	54.33% ★★	52.99% ★★	53.67%
Ages 12 to 17 Years	58.33% ★★	61.74% ★★	60.70% ★★	60.83%
Total	56.45% ★★	59.10% ★★	57.85% ★★	58.18%
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	NA	70.19% ★★★★	67.01% ★★★	68.63%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	NA	74.70% ★★★	72.38% ★★★	73.55%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	51.29% ★	53.82% ★	56.10% ★	53.89%
Ages 12 to 17 Years	54.62% ★★	58.04% ★★★	61.47% ★★★★	58.42%
Ages 18 to 21 Years	24.32% ★	29.22% ★★	31.60% ★★	28.83%
Total	49.17% ★	52.22% ★★	54.70% ★★	52.27%
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Ages 18–64 Years**	25.00% ★	10.73% ★★	8.97% ★★★	10.30%
*Expected Readmissions—Ages 18–64 Years**	8.99% NC	9.06% NC	9.19% NC	9.12%
*Observed/Expected Ratio—Ages 18–64 Years**	2.7804 ★	1.1841 ★★	0.9755 ★★★★	1.1285
Measures Reported Using Electronic Clinical Data Systems (ECDS)				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	NA	58.63% ★★★	63.15% ★★★★	61.62%
Colorectal Cancer Screening (COL-E)				
Ages 46 to 50 Years	NA	33.66% ★★★	43.05% ★★★★★	39.06%
Ages 51 to 75 Years	NA	46.50% ★★★	57.55% ★★★★★	53.70%
Total	NA	43.12% ★★★	54.58% ★★★★★	50.39%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder [ADHD] Medication (ADD-E)				
Initiation Phase	NA	46.50% ★★	48.37% ★★★	47.48%
Continuation and Maintenance Phase	NA	51.20% ★★	51.02% ★★	51.10%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)				
Blood Glucose Testing—Ages 1 to 11 Years	34.76% ★	49.47% ★★★	41.08% ★★	42.84%

HEDIS Measures	MHN	NTC	UHCCP	Nebraska Medicaid Managed Care Weighted Average
Blood Glucose Testing—Ages 12 to 17 Years	60.80% ★★	67.09% ★★★	54.44% ★	60.28%
Blood Glucose Testing—Total	50.56% ★	60.48% ★★★	49.50% ★	53.72%
Cholesterol Testing—Ages 1 to 11 Years	25.71% ★	37.43% ★★★	30.25% ★★	31.94%
Cholesterol Testing—Ages 12 to 17 Years	32.41% ★	46.71% ★★★	32.19% ★	37.54%
Cholesterol Testing—Total	29.78% ★	43.23% ★★★	31.47% ★	35.43%
Blood Glucose and Cholesterol Testing—Ages 1–11 Years	22.86% ★	35.83% ★★★	28.67% ★★	30.09%
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years	31.48% ★	44.94% ★★★	31.13% ★	36.25%
Blood Glucose and Cholesterol Testing—Total	28.09% ★	41.52% ★★★	30.22% ★	33.93%
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	0.00% ★	1.82% ★	42.48% ★★★★★	13.15%
Follow-Up on Positive Screen	NA	NA	NA	NA
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	0.00% ★	1.00% ★	42.28% ★★★★★	16.10%
Follow-Up on Positive Screen	NA	NA	NA	NA

* 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 2024 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
HEDIS MY 2024 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 2025–2026 (review period), HSAG reviewed six 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 2024–2025 compliance reviews were evaluated and resolved in 2025.

Results

Table 2-6—MCO Compliance Monitoring Results for CY 2025–2026

Standard Number and Title*	MHN**	NTC**	UHCCP**	Total
Standard I—Enrollment and Disenrollment	100%	90%	50%	80%
Standard II—Member Rights and Confidentiality				
Standard III—Member Information				
Standard IV—Emergency and Poststabilization Services				
Standard V—Adequate Capacity and Availability of Services	89%	83%	94%	89%
Standard VI—Coordination and Continuity of Care				
Standard VII—Coverage and Authorization of Services				
Standard VIII—Provider Selection and Program Integrity	89%	100%	100%	96%
Standard IX—Subcontractual Relationships and Delegation	100%	86%	100%	95%
Standard X—Practice Guidelines				
Standard XI—Health Information Systems	100%	89%	100%	96%
Standard XII—Quality Assessment and Performance Improvement	100%	100%	100%	100%
Standard XIII—Grievance and Appeal System				
Totals	**94%**	**94%**	**94%**	**94%**

* Bold text indicates standards that HSAG reviewed during CY 2025–2026.
**Grey shading indicates standards that were not reviewed during CY 2025–2026.

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.[3] DHHS contracted HSAG to conduct a NAV during EQR CY 2025–2026. 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) reported 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 provided for informational purposes only.

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

[3] 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 4, 2026.

Results

Aggregated ISCA and NAV Results

This section presents an overview of the ISCA and NAV results for CY 2025–2026, with data collected as of March 31, 2025. 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*
MHN				
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 March 31, 2025. 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.[4] Analyses for OB/GYN were limited to female members 15 years of age and older.

[4] 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.

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

Member Population	MHN	NTC	UHCCP
Children 18 Years and Younger	57,983	60,147	59,552
Females 15 Years and Older	38,844	40,525	40,209
All Members*	116,059	114,583	114,482

*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	MHN	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
PCP, Urban	100.0%	100.0%	100.0%
PCP, Rural	100.0%	>99.9%^	100.0%
PCP, Frontier	100.0%	100.0%	100.0%
High-Volume Specialists**			
Cardiology	99.9%^	100.0%	>99.9%^
Neurology	100.0%	100.0%	>99.9%^
OB/GYN	100.0%	100.0%	100.0%
Oncology-Hematology	99.7%^	99.8%^	99.8%^
Orthopedics	100.0%	100.0%	100.0%
Pharmacy, Urban	96.6%	95.8%	96.3%
Pharmacy, Rural	91.9%	91.4%	93.4%
Pharmacy, Frontier	97.7%	97.5%	97.8%
All Behavioral Health Inpatient and Residential Service Providers, Urban	100.0%	100.0%	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Rural	100.0%	100.0%	100.0%
All Behavioral Health Inpatient and Residential Service Providers, Frontier	100.0%	100.0%	100.0%
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%^	99.9%^	>99.9%^

Provider Category	MHN Percent of Members With Required Access*	NTC Percent of Members With Required Access*	UHCCP Percent of Members With Required Access*
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	99.8%^	97.7%^	98.3%^
Hospitals	99.1%^	99.4%^	99.2%^
Optometry, Urban	95.2%^	>99.9%^	>99.9%^
Optometry, Rural	85.3%^	>99.9%^	>99.9%^
Optometry, Frontier	76.3%^	100.0%	100.0%
Ophthalmology, Urban	97.6%^	98.0%^	98.1%^
Ophthalmology, Rural	>99.9%	100.0%	100.0%
Ophthalmology, Frontier	87.5%^	100.0%	91.3%^
Dental			
Dentist, Urban	>99.9%^	100.0%	100.0%
Dentist, Rural	99.9%^	>99.9%^	99.9%^
Dentist, Frontier	100.0%	100.0%	100.0%
Dental Specialists			
Oral Surgeon, Urban	73.9%^	92.9%	88.6%
Oral Surgeon, Rural	57.1%^	78.7%	65.2%^
Oral Surgeon, Frontier	18.0%^	55.2%^	22.4%^
Orthodontist, Urban	82.2%^	84.7%^	83.0%^
Orthodontist, Rural	50.7%^	67.6%^	58.7%^
Orthodontist, Frontier	79.1%	100.0%	78.4%
Periodontist, Urban	59.0%^	23.6%^	76.8%^
Periodontist, Rural	18.6%^	29.3%^	37.5%^
Periodontist, Frontier	0.0%^	0.0%^	0.0%^
Endodontist, Urban	59.0%^	72.7%^	76.8%^
Endodontist, Rural	18.6%^	33.5%^	37.9%^
Endodontist, Frontier	0.0%^	0.0%^	0.0%^
Prosthodontist, Urban	59.0%^	51.7%^	76.8%^
Prosthodontist, Rural	19.3%^	18.3%^	37.6%^
Prosthodontist, Frontier	0.0%^	0.0%^	0.0%^
Pediadontist, Urban	96.7%	97.5%	97.5%
Pediadontist, Rural	83.5%	79.5%	84.4%
Pediadontist, Frontier	84.6%	85.4%	86.8%

Red shaded cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type, in a specific urbanicity. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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 geographic network distribution analysis.

The MCOs performed strongly across many provider types and urbanicities. All MCOs met the time and distance standards for all urbanicities or statewide for High-Volume OB/GYN, High-Volume Orthopedics, All Behavioral Health Inpatient and Residential Service Providers, Pharmacy, and Pediadontist provider types.

Where the MCOs failed to meet a given standard, there were many instances in which the MCO was just below the required member access threshold (e.g., 99.9 percent rather than 100 percent). HSAG noted general alignment between the MCOs' self-reported time and distance standard results for primary care providers (PCPs), high-volume specialists, dentists, pharmacies, and behavioral health inpatient and outpatient providers. While percentages varied slightly, the MCO-reported and HSAG-calculated results were very similar. HSAG identified a broader range of variance across urbanicities between the MCOs' self-reported time and distance standard results and the HSAG-calculated compliance results for dental specialist provider types.

Additional EQR Activities

Network Adequacy Dashboard

Results

The Network Adequacy Dashboard was intended to support DHHS and the MCOs by presenting a visual representation of network adequacy results. Based on the Geographic Access results, HSAG identified the provider categories for which each MCO failed to meet the established standard at the county-level. For this purpose, HSAG used the MCOs' categorization of providers as they reported to DHHS. HSAG incorporated DHHS' feedback into the final version of the NAV dashboard, reflecting CY 2025–2026 results and provided DHHS with a Tableau dashboard containing MCO-specific results for the study indicators.

HSAG collaborated with DHHS to review and align provider classification criteria across MCO for comparative purposes. HSAG presented detailed current time/distance results to DHHS and the MCOs in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. In addition, where the MCOs failed to meet standards, HSAG also presented an exploratory analysis available to DHHS only, that identified similar Medicaid-enrolled providers who could be potential targets for strengthening the MCOs' provider networks for DHHS' use in evaluating MCOs' provider recruitment efforts.

Provider Directory Validation and Secret Shopper Survey

Results

PDV and secret shopper survey results were not final at the time of reporting. Final results from this activity will be included in the CY 2026–2027 EQR Technical Report.

Quality Strategy Evaluation

Regulations at 42 CFR §438.340(c)(2), (c)(2)(i), and (c)(2)(ii) require states to review and update their quality strategy as needed, but no less than every three years. A state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. HSAG assisted DHHS with its Quality Strategy evaluation in accordance with CMS' *Quality Strategy Toolkit for States*.[5] The Quality Strategy evaluation was included in the State's 2023 Quality Strategy.

Table 2-10—Recommendations for Heritage Health Program

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
Quality	HSAG recommended 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.	• DHHS tied Quality Performance Program (QPP) dollars to incentivize MCO performance in the HEDIS measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) in 2021, 2022, 2023, and 2024. • The MCOs identify members with specific HEDIS gaps for outreach. The case management team addresses care gaps in WCC and Child and Adolescent Well-Care Visits (WCV) during telephonic interaction with the member or authorized representative. • The MCOs also utilize Community Health Workers (CHW) to complete targeted outreaches which includes education to authorized representatives regarding the body mass index (BMI) assessment, nutritional and physical activity counseling by providers at well-child visits.

[5] Centers for Medicare & Medicaid Services. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: Feb 4, 2026.

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
			• The MCOs provide education to providers through their clinical provider representatives. Practitioners and/or clinics are provided with updated member specific compliance data and education. Specific to the WCC measure, the clinical provider representatives discuss the importance of documenting BMI, nutrition, and physical activity counseling in the member's medical record in accordance with NCQA guidance. • The MCOs have offered providers the opportunity to engage in Value Based Contracting (VBC) to address opportunities in care and have implemented VBCs on WCC over the course of several years. • The MCO Chief Medical Officer (CMO) engages in ongoing education and discussion at various meetings with providers on approaches to improve WCC screening rates, as well as documentation regarding BMI, nutrition, and physical activity counseling. • The MCOs conduct various communication campaigns such as interactive voice recording reminders and educational mailers to prompt members to schedule appointments and close the identified gap in care. • Member incentives are offered as gift cards to members who schedule and attend an appointment to complete their annual well-child visit. Eligibility for this program is

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
			based off the WCV measure to provide reminders of the need for annual preventive care appointments. • Member education is also provided via the Member Handbook and Member Portal regarding the importance of an annual well-child visit, as well as language that specifically addresses that the exam should include weight (BMI) assessment, counseling for nutrition, and counseling for physical activity.
Quality	HSAG recommended 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.	• One of the MCOs has created a workgroup to address Antibiotic stewardship as it relates to URI and Acute bronchitis. The workgroup has completed a root cause analysis and pulls a list of the lower performing providers. The CMO provides education through webinars etc. with a discussion on the current literature on the overuse of antibiotics. • The MCOs are working on identifying noncompliant claims for any additional diagnoses that would justify the prescription of an antibiotic.
Quality, Timeliness, and Access	HSAG recommended 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.	• DHHS tied QPP dollars to incentivize MCO performance in the HEDIS measure Initiation and Engagement of Substance Use Disorder Treatment (IET) since 2021. • The MCOs send out emails and portal messages to members identified with an open IET gap. • The MCO Care and Case Managers conduct outreach to members following emergency department visits and hospital discharges related

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
			to substance use. Outreach includes providing education on the importance of timely follow up care, assisting with appointment scheduling, coordinating transportation, and assessing for additional social determinant of health needs. • The MCO pharmacist is used to review reports of members with new prescriptions for medications used to treat alcohol and opioid use disorders. CHWs contact these members to confirm they received their medications, have scheduled follow up appointments, and have access to transportation. • All identified members are offered the opportunity to enroll in Case Management services. • The IET HEDIS measure is difficult because: – Of the complexity of the technical specifications of the measure and inconsistencies in coding, – CFR 42 poses a barrier to the ability to communicate with providers, and – Limited availability of providers who provide medication assisted treatment (MAT).
Quality and Access	HSAG recommended 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.	Expand access to high-quality services to meet the needs of diverse clients.	• DHHS contractually requires each MCO to have a Health Equity committee and to have health equity representation on their other healthcare committees. Other contractual requirements include

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
	HSAG also recommends that the MCOs identify best practices for ensuring children receive timely and medically appropriate well-care services.	Promote wellness and prevention.	tribal representation and the Member Advisory Committee. • The MCOs use data and dashboards to identify disparities and address HEDIS measures in context of the findings. • One MCO sends out Provider Profiles that include disparate groups —specifically for measures Breast Cancer Screenings and Colorectal Cancer Screenings. • Some MCOs are participating in a Doula pilot. • The MCOs, in accordance with NCQA accreditation, conduct an annual disparities analysis that includes at least three valid clinical measures and one member experience measure stratified by race/ethnicity, language, and at least one additional demographic factor such as age. HEDIS measures studied include WCV, PPC, CHL. Findings are used to implement targeted intervention to reduce observed disparities informed by the results of a completed root cause analysis. • One MCO identified three counties that were at highest risk for Lead and started targeted Lead screening outreach (Douglas, Lancaster, and Burt). This outreach will be completed by the end of March 2026 and outreach to additional counties will then begin. Quarterly text messaging for Lead screening has also been launched. • DHHS has tied QPP dollars to incentivize MCO performance in the

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
			HEDIS measure Well-Child Visit in 2025. • The MCOs identify members with specific HEDIS gaps for outreach. The case management team addresses care gaps in WCV during telephonic interaction with the member or authorized representative. • The MCOs also utilize CHWs to complete targeted outreaches which includes education to authorized representatives. • The MCOs provide education to providers through their clinical provider representatives. Practitioners and/or clinics are provided with updated member specific compliance data and education. • The MCOs have offered providers the opportunity for incentive payments and to engage in VBC to address opportunities in care and implemented VBCs on WCV over the course of several years. • Member incentives are offered as gift cards to individuals who schedule and attend an appointment to complete their annual well-child visit. Eligibility for this program is based off the WCV measure to provide reminders of the need for annual preventive care appointments. • Member education is also provided via text messaging, audiovisual aids (videos), the Member Handbook and Member Portal regarding the importance of an annual well-child visit.

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
Quality, Timeliness, and Access	HSAG recommended 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.	DHHS agrees with HSAG's recommendation and will work collaboratively with each MCO to review the compliance monitoring report, including detailed findings and recommendations, to ensure appropriate follow-up and corrective actions.
Quality, Timeliness, and Access	HSAG recommended 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 (NABDs) 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 NABDs is consistent with the requirements, and accurately report appeals information to DHHS.	Timely decision making.	DHHS acknowledges HSAG's position that post decision discussions that result in a change in outcome are being viewed as functionally equivalent to an appeal once an NABD has been issued. The intent with reconsiderations is the opportunity for the provider to submit missing or additional medical documentation and the intent for the peer to peer discussion is clinical dialogue and clarification, not an alternative appeal pathway. An alternative approach would be to allow post decision reconsiderations and peer to peer discussions to occur but treat them as non-determinative, meaning the adverse determination is not overturned outside of the formal appeal process. That framework preserves appeal rights and reporting integrity while still supporting provider communication. However, this may lead to additional provider abrasion with having to rely on formal processes (and additional administrative burden) to communicate additional information that may support an overturn. Reconsiderations and peer-to-peer discussions prior to determination are limited due to the regulatory turnaround time necessary for decision making.

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
Access	HSAG recommended 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.	DHHS agrees with HSAG's recommendation and will work with the MCOs regarding the provider categories they did not meet the time/distance standard and request the MCOs assess the reasons for non-compliance.
Access	HSAG recommended 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.	• The MCOs use a combination of network, member engagement, provider incentives, and operational strategies to improve timely and equitable access to care. Improving member access to care is most effective with the combination of: – Strong network adequacy, – Proactive and multimodal member outreach, – Appropriately designed member and provider incentive programs, – Interventions that address nonclinical barriers, and – Ongoing, equity focused data monitoring. These approaches support timely access to services, improved preventive care utilization, and better overall member outcomes while aligning with managed care requirements and quality expectations. • Member experience surveys: these surveys provide insight into opportunities for improvement such as transportation, access to dental

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
			services and coverage for pharmaceutical products. • One MCO sends mobile dental and vision vans into rural Nebraska to provide services. • The MCOs collaborate closely with Community Based Organizations and the FQHCs. Opportunities for improvement include enhancing school-based care and targeting sports physicals to be well-child visits when the elements of the member's evaluation can be incorporated appropriately. • The MCOs use member incentive programs to encourage the use of preventive and routine care: – The MCOs offer member incentives for completing preventive visits, screenings, health risk assessments, or other health promoting activities, and – Align member incentives with provider incentives and evaluate these incentive programs for effectiveness and equity impacts.
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. Increase provider satisfaction.	• This is a contract requirement and is currently live for the MCOs since January 1, 2025. • The MCOs are implementing CMS Interoperability requirements to post prior authorization data on their websites by the compliance date of March 31, 2026.

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
	• 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.		
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	Expand access to high-quality services to meet the needs of diverse clients. Increase member satisfaction.	DHHS agrees with HSAG regarding the maximum appointment wait times. We will review and update the contract as needed. Thank you for the recommendation to contract with a vendor to perform secret shopper surveys of MCO compliance with appointment wait times and accuracy of provider directories. We will discuss this further internally. Thank you for the recommendation to conduct an annual member experience survey. We will discuss this further internally.

Program Recommendations			
Domain	**Recommendations**	**Associated Quality Strategy Goal(s)**	**DHHS Response**
	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).		

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 the CMS EQR Protocol 1 *Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[6]

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

[6] 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 4, 2026.

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 the CMS EQR Protocol 1,[7] 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:

[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 4, 2026.

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 the CMS EQR Protocol 1[8] 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
MHN	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	✓	✓	✓
MHN	*Health Risk Screener Completion in Pregnant Members*	✓	✓	
NTC	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	✓	✓	✓
NTC	*Health Risk Screener Completion in Pregnant Members*	✓	✓	
UHCCP	*Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*	✓	✓	✓
UHCCP	*Health Risk Screener Completion in Pregnant Members*	✓	✓	

[8] 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 4, 2026.

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 2024 to undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA LO. The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[9] 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 three MCOs that underwent a HEDIS Compliance Audit this year for the calendar year 2024 measurement period (i.e., MY 2024)—**MHN**, **NTC**, and **UHCCP**—and aggregated several sources of HEDIS-related data to confirm that the MCOs met the HEDIS Information Systems (IS) compliance standards and had the ability to report HEDIS data accurately. HSAG received the MY 2024 FARs and Interactive Data Submission System (IDSS) workbooks from **MHN**, **NTC**, and **UHCCP** by August 1, 2025, and completed the review of these materials by August 22, 2025.

[9] 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 4, 2026.

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*.[10]

- 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 medical record review (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 2024 rates as presented within the NCQA-published IDSS completed by the MCO and/or its contractor.

MHN, **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 2024 to report on selected measures from the CMS Adult and Child Core Sets using a DHHS-supplied

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

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 three MCOs that reported Core Set measure data to DHHS for MY 2024 and received completed templates by September 30, 2025. 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 2024 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 2024 rates are reportable. **UHCCP** did not provide a validation report but confirmed that its Adult and Child Core Set measure rates were independently validated. **MHN** did not provide a validation report and confirmed that its Adult and Child Core Set measure rates were not independently validated.

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 2024.

Table 3-2—CMS Core Set Measures Required by DHHS for MY 2024

Performance Measures
CMS Adult Core Set Measures
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) [Rate 1]
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

Performance Measures
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
Concurrent Use of Opioids and Benzodiazepines (COB-AD)
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)
Contraceptive Care—All Women Ages 21 to 44 (CCW-AD)
CMS Child Core Set Measures
Developmental Screening in the First Three Years of Life (DEV-CH)
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)
*Oral Evaluation, Dental Services (OEV-CH)**
*Sealant Receipt on Permanent First Molars (SFM-CH)**
*Prevention: Topical Fluoride for Children (TFL-CH)**

* DHHS required MCOs to report these Child Core Set dental health measures starting in MY 2024.

How Data Were Aggregated and Analyzed

HEDIS Reporting

HSAG collected IDSS files and FARs for MY 2024 from **MHN**, **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 2024 percentile benchmarks.

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 2024 from **MHN**, **NTC**, and **UHCCP**. In addition to the MY 2024 Core Set reporting template, **NTC** provided HSAG with documentation confirming that its MY 2024 rates on the DHHS-selected Adult and Child Core Set measures were independently validated. **UHCCP** did not provide documentation but confirmed that its MY 2024 rates on the Adult and Child Core Set measures were independently validated. Lastly, **MHN** did not provide documentation and confirmed that its MY 2024 rates on the Adult and Child Core Set measures were

not independently validated. HSAG presented **NTC**'s and **UHCCP**'s independently validated Core Set measure rates in this report and did not present **MHN**'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*.[11] 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 2024 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 2024, 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:

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

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

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 2024 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2024.

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, tetanus, diphtheria toxoids, and acellular pertussis [Tdap])	✓		
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, human papillomavirus [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	✓		

Performance Measures	Quality	Timeliness	Access
CHL: Chlamydia Screening in Women—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	✓		
PCE: Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (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 (<140/90 mm Hg)	✓	✓	
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	
Effectiveness of Care: Diabetes			
GSD: Glycemic Status Assessment for Patients With Diabetes—Glycemic Status 8.0%	✓		
GSD: Glycemic Status Assessment for Patients With Diabetes—Glycemic Status > 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	✓		
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	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
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	✓	✓	✓
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	✓		✓
Effectiveness of Care: Overuse/Appropriateness			
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	✓		

Performance Measures	Quality	Timeliness	Access
URI: Appropriate Treatment for Upper Respiratory Infection—Total	✓		
LBP: Use of Imaging Studies for Low Back Pain—Ages 18 to 64 Years	✓		
LBP: Use of Imaging Studies for Low Back Pain—Ages 65 to 75 Years	✓		
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	✓	✓	✓
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	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
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	✓		✓
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	✓		
COL-E: Colorectal Cancer Screening—Ages 46 to 50 Years	✓		
COL-E: Colorectal Cancer Screening—Ages 51 to 75 Years	✓		
COL-E: Colorectal Cancer Screening—Total	✓		
ADD-E: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	✓	✓	
ADD-E: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	✓	✓	
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Ages 1 to 11 Years	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Ages 12 to 17 Years	✓		

Performance Measures	Quality	Timeliness	Access
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Ages 1 to 11 Years	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Ages 12 to 17 Years	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years	✓		
APM-E: Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	✓		
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)	✓	✓	✓
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]	✓		✓
Contraceptive Care—All Women Ages 21 to 44 (CCW-AD)	✓	✓	✓

Core Set Measures	Quality	Timeliness	Access
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)	✓	✓	✓
Oral Evaluation, Dental Services (OEV-CH)	✓		
Sealant Receipt on Permanent First Molars (SFM-CH)	✓		
Prevention: Topical Fluoride for Children (TFL-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 2024–2025 compliance reviews were evaluated and resolved in 2025.

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

	CY 2022–2023	CY 2023–2024	CY 2024–2025	CY 2025-2026
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	✓			✓
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 the CMS EQR Protocol 3.[12] 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.

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2026.

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 credentialing and recredentialing cases, and subcontractor/vendor agreements 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 2025–2026 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 the 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 I—Enrollment and Disenrollment	✓		✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VIII—Provider Selection and Program Integrity	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		

Validation of Network Adequacy

Objectives

In accordance with 42 CFR §438.68, CMS EQR Protocol 4. *Validation of Network Adequacy*: *A Mandatory EQR-Related Activity*,[13] 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 CMS EQR Protocols in February 2023, validation of the MCOs' compliance with these network adequacy standards is a mandatory EQR activity. HSAG validated MCO information systems and processes for collecting data as it applies to network adequacy indicators for the preceding 12 months, ending with the quarterly GeoAccess reports submitted to DHHS on March 31, 2025.

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 validated indicators are listed in Appendix E.
2. Perform an independent time and distance analysis calculating the percentage of members with access to providers within the 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 the CMS Protocol 4.[14] The ISCAT was designed to collect information and evaluate the capabilities of each MCO's IS infrastructure to monitor network standards in accordance with the requirements of the protocol. The document request packet, which included the ISCAT, asked for 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

[13] 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, 2026.

[14] Ibid.

indicator methodology, and accuracy in network adequacy reporting at the indicator level. The HSAG EQRO team members, MCO staff, and all applicable vendors collaborated to identify all data sources informing calculation and reporting at the network adequacy indicator level.

The document request packet 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 offered 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 March 31, 2025, 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 the MCOs' Medicaid members. HSAG requested the following key data elements: provider name, national provider identifier (NPI), address, provider category used for reporting in the quarterly GeoAccess reports, provider type, specialty, and taxonomy codes.

HSAG requested quarterly GeoAccess reports from both the MCOs and DHHS for the period from January 1, 2025, through March 31, 2025.

Description of Data Obtained

The following key types of data were obtained and reviewed as part of the CY 2025–2026 NAV activity:

ISCA

- ISCATs and requested documentation submitted by each MCO
- Virtual review sessions attended 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 March 31, 2025.
- Provider data files from the MCOs showing providers contracted in their network as of March 31, 2025.

- Quarterly network adequacy reports submitted by the MCOs to DHHS for 2025.

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 IS 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 software 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 to render services to individuals.[15] 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 are informational only and are 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 conducted for information only.

HSAG aggregated and analyzed all of the data obtained and the results of its independent analysis and used the CMS EQR Protocol 4[16] Worksheet 4.6 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?

[15] 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.

[16] 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, 2026.

- 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?

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 were 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			✓
CMS EQR Protocol 4 Information Systems Capabilities Assessment—Validation of network adequacy assessment data, methods, and results			✓

Network Adequacy Dashboard

Objectives

The Network Adequacy Dashboard was intended to support DHHS and the MCOs by presenting a visual representation of network adequacy results. Based on the Geographic Access results, HSAG identified the provider categories for which each MCO failed to meet the established standard at the county-level. For this purpose, HSAG used the MCOs' categorization of providers as they reported to DHHS.

HSAG incorporated DHHS' feedback into the final version of the NAV dashboard, reflecting CY 2025-2026 results and providers DHHS with a Tableau dashboard containing MCO-specific results for the study indicators.

Dashboards included:

- An overview of health plan network compliance with time and distance standards stratified by county and provider type.
- A county-level map with colors showing how well a selected health plan performed on meeting time and distance standards for a specified provider type.
- A county-level map with results for the average time and distance to the nearest three providers for each plan and specified provider type.

Saturation Analysis

For provider types that did not meet the time/distance requirements, HSAG also provided an exploratory saturation analysis to assess whether it could determine the degree to which each MCO's provider network reflects available providers. The saturation analysis aimed to support DHHS in assessing the extent to which deficiencies in provider networks resulted from a failure to contract with available providers versus a lack of available providers for a specified provider type or region.

This dashboard was restricted to access by DHHS in the current year.

Technical Methods of Data Collection

HSAG utilized the data collected for the NAV activity and collaborated with DHHS to standardize classification criteria for provider types across the MCOs as applicable.

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 offered a technical assistance call to review the data request in detail and clarify any questions regarding the request. HSAG requested data for members actively enrolled in an MCO as of March 31, 2025, 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 each MCO, HSAG requested provider files reflecting all active providers serving the MCO's 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 from the MCOs for the period of January 1, 2025, through March 31, 2025.

Description of Data Obtained

As part of the CY5 NAV activity, the following key types of data were obtained and reviewed for use in the saturation analysis:

- Medicaid member data files from DHHS for members enrolled in an MCO as of March 31, 2025
- Provider data files from the MCOs showing providers contracted in their network as of March 31, 2025
- Quarterly network adequacy reports submitted by the MCOs to DHHS for 2025

How Data Were Aggregated and Analyzed

Based on the time/distance validation results, HSAG identified the provider categories for which each health plan failed to meet the established standard at the county level. However, given the absence of a specific provider crosswalk from DHHS, the MCOs varied in how providers were matched to indicators. To provide maximum comparability across the MCOs, HSAG collaborated with DHHS to determine any limitations that should be applied in identifying the provider types intended to be covered in its network standards. For example, HSAG considered information provided by the MCOs regarding providers' taxonomy codes, specialty codes, and provider licensing to identify which providers would be considered as resources available to the MCOs to meet contract standards. If the results are deemed useful, this analysis may be made available to MCOs in future years.

How Conclusions Were Drawn

HSAG analyzed the quantitative results obtained from the saturation analysis to identify provider categories for which the MCOs failed to meet the time and distance standard, and whether a provider was available in the specified county to help support the MCO's care network. HSAG then identified strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of care furnished by each MCO.

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 the three domains of care. This assignment to domains of care is depicted in Table 3-10.

Table 3-10—Assignment of Network Adequacy Dashboard Activities to the Quality, Timeliness, and Access Domains

Network Adequacy Dashboard Activity	Quality	Timeliness	Access
Saturation Analysis—Assessing robustness of MCO provider networks and availability of providers to address gaps in meeting network standards across the MCOs			✓

Provider Directory Validation and Secret Shopper Survey

Objectives

The goal of the provider directory validation (PDV) and secret shopper survey was to assess the accuracy of the managed care network information supplied to Heritage Health program members using three sources: the MCOs' provider data files, the MCOs' online provider directories, and secret shopper survey calls to sampled provider locations. Additionally, the secret shopper survey assessed appointment availability and compliance with DHHS' wait time standards.

The PDV compared key indicators published in each online provider directory with the data in the MCO's provider file to confirm accuracy of provider information. HSAG then validated the accuracy of the components of the online provider directories by completing a secret shopper telephone survey. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate location information). The secret shopper telephone survey allowed for objective data collection from health care providers without potential bias introduced by knowing the surveyor's identity.

Technical Methods of Data Collection

HSAG conducted the PDV and secret shopper survey in November and December 2025. Using DHHS-approved data request materials, the MCOs identified providers potentially eligible for survey inclusion and submitted the data files to HSAG. The eligible population included service locations associated with primary care, maternal care, dental, and behavioral health providers that were actively contracted with the MCO at the time the data file was created, to serve individuals enrolled in the Heritage Health program. Providers with contract expiration dates within the survey field were excluded from the sample frame. Service locations with addresses in contiguous states were included in the sample frame if they were actively contracted with the MCO.

Upon receipt of the MCOs' data files, HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, service telephone number, service street address, provider name, NPI, provider type, provider specialty, provider taxonomy code, and new patient acceptance indicator.

Description of Data Obtained

The following random sampling approach was used to generate a list of provider locations (i.e., "cases") from each MCO for inclusion in the survey:

- **Step 1:** HSAG assembled the sample frame using records from all service locations identified by each MCO.

  - To minimize duplicated provider records within each MCO, HSAG standardized the providers' address data to align with the United States Postal Service (USPS) Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. The original provider address data values were retained for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county).
  - Service locations that did not accept new patients were excluded from the sample frame. New patient acceptance was identified from an indicator in the MCOs' data submissions to HSAG.
  - Provider locations not listed in the online directory as indicated by the MCO or providers who covered services at the specified location rather than accepting appointments to see patients at the location were excluded from the sample.
- **Step 2:** HSAG used the sample frame to determine a statistically valid number of unique provider locations[17] based on a 95 percent confidence level and ±5 percent margin of error at the urbanicity level. A 25 percent oversample was included to increase the probability of capturing appointment availability information from a statistically valid number of service locations. The sample size was 1,418 providers across all MCOs and provider types.

How Data Were Aggregated and Analyzed

For each sampled case, HSAG compared the MCO's provider data values to the information in the MCO's online directory for the following list of indicators. All items were required to match, excluding common USPS standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Indicator 1—Provider Found in Directory
- Indicator 2—Address: Street Address
- Indicator 3—Address: Suite Number
- Indicator 4—Address: City
- Indicator 5—Address: State
- Indicator 6—Address: ZIP Code
- Indicator 7—Telephone Number
- Indicator 8—Provider Type/Specialty (matches the sampled provider specialty category)
- Indicator 9—Accepting New Patients

[17] To minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple addresses within an MCO, HSAG randomly assigned the number to an MCO and standardized address, prioritizing assignment to the least-represented MCOs. HSAG worked with DHHS to amend this approach, as needed, following HSAG's initial review of the MCOs' data.

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online directory and the provider data extract.
- No, the information did not match between the online directory and the provider data extract.
- The information was not listed in the provider data and could not be confirmed in the online directory.
- The information was not listed in the online directory and could not be confirmed.

Using a DHHS-approved survey script, HSAG classified survey indicators into domains that considered provider data accuracy and appointment availability by MCO. Provider data accuracy was evaluated based on survey responses. In general, matched information received a "Yes" response and non-matched information received a "No" response. For data collected on the first available appointment, the average wait time was calculated based on call date and earliest appointment date. HSAG also assessed appointment availability in relation to DHHS' appointment standards.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's confirmation of offering the requested services
- Accuracy of accepting Heritage Health with the requested MCO

HSAG collected the following access-related information when calling sampled locations:

- Information concerning whether the provider location was accepting new patients.
- Next available new patient appointment date with any practitioner at the sampled location for:
  - Routine well-check appointment for primary care.
  - First trimester (i.e., initial) prenatal appointment for maternal care.
  - Routine teeth cleaning appointment for dental.
  - Initial therapy appointment for behavioral health.
- Any limitations offered by the survey respondent regarding new patient acceptance or appointment availability. Limitations included but were not limited to:
  - A review of the member's medical records prior to offering an appointment.
  - Registration with the practice prior to offering an appointment.
  - Verification of the member's Medicaid eligibility prior to offering an appointment.
  - Initial evaluation prior to offering an appointment.

How Conclusions Were Drawn

HSAG determined that results of the PDV and secret shopper activity could provide information about MCO performance related to the quality, timeliness, and access domains of care. HSAG used analysis of the PDV and secret shopper survey data to draw conclusions about Heritage Health members' access to particular provider networks (i.e., primary, maternal, dental, or behavioral 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.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MCOs, HSAG assigned each of the components reviewed for the PDV and secret shopper survey to one or more of the three domains of care. This assignment to domains of care is depicted in Table 3-11.

Table 3-11—Assignment of PDV and Secret Shopper Survey Activities to the Quality, Timeliness, and Access Domains

PDV and Secret Shopper Survey Activity	Quality	Timeliness	Access
PDV	✓		✓
Secret Shopper Survey	✓	✓	✓

Validation of Performance Improvement Projects

Results

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

MHN submitted the clinical PIP, *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*, focused on quality, timeliness, and access domains of healthcare for sexually active women through efforts to increase the percentage of women who receive an annual chlamydia screening, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table A-1 summarizes **MHN**'s PIP validation scores.

Table A-1—2025–2026 PIP Validation Results for MHN

PIP Topic	Type of Review[1]	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		
		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]
Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years	Initial Submission	80%	71%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

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 A-9 presents baseline performance indicator data for **MHN**'s *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, which was used to objectively assess for improvement.

Table A-2—Performance Indicator Results for the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N: 1,062 D: 2,811	37.8%					*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **MHN** reported that 37.8 percent of women 16–24 years of age who were identified as sexually active had at least one test for chlamydia during the measurement year.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

MHN submitted the nonclinical PIP, *Health Risk Screener Completion in Pregnant Members*, focused on quality and timeliness domains of healthcare for members who are pregnant, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table A-3 summarizes **MHN**'s PIP validation scores.

Table A-3—2025–26 PIP Validation Results for MHN

PIP Topic	Type of Review[1]	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		
		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]
Health Risk Screener Completion in Pregnant Members	Initial Submission	60%	57%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

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 A-4 presents baseline performance indicator data for **MHN**'s *Health Risk Screener Completion in Pregnant Members* PIP, which was used to objectively assess for improvement.

Table A-4—Performance Indicator Results for the *Health Risk Screener Completion in Pregnant Members* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of pregnant members completing the Health Risk Screener within 21 days of enrollment (while pregnant) or pregnancy identification during the measurement period.	N: 24 D: 1,649	1.5%					*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **MHN** reported that 1.5 percent of pregnant members completed the Health Risk Screener within 21 days of pregnancy identification or enrollment while pregnant.

Interventions

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

For the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, **MHN** used brainstorming to identify the barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation and include the barriers and interventions as documented by **MHN**.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

For the *Health Risk Screener Completion in Pregnant Members* PIP, **MHN** used brainstorming, plan-specific data analyses, and a fishbone diagram to identify and summarize barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation, and include the barriers and interventions as documented by **MHN.**

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table A-5 for each activity. This table highlights the extent to which **MHN** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **MHN** can best address opportunities identified for each activity.

Table A-5—MHN Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength: MHN** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP. The MCO used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength: MHN** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Health Risk Screener Completion in Pregnant Members* PIP. The MCO used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since **MHN** began operations on January 1, 2024, last year's report did not include such an evaluation for this MCO.

Validation of Performance Measures

Results for Information Systems Standards Review

Table A-6 provides a summary of **MHN**'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 A-6—Summary of Compliance With IS Standards for MHN

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 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. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• **MHN** was compliant with IS Standard R for data management and reporting. • The LO determined that **MHN** 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 **MHN** was compliant with the standard for oversight and controls that ensures correct implementation of measure reporting software.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
	• The LO confirmed that **MHN** had practices in places to promote protection and resiliency of systems and data. • Sufficient 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.	• **MHN** was compliant with IS Standard C for clinical and care delivery data. • The LO determined that **MHN** had policies and procedures in place for submitted data that conform with industry standards. • Sufficient 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.	• **MHN** was compliant with IS Standard M for medical record review 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.	• **MHN** 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 MHN. According to the DHHS' required data collection methodology, the rates displayed in Table A-7 reflect all final reported rates in MHN's IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that MHN 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 A-7—HEDIS Audit Results for MHN

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 reported using ECDS).	Unaudited	***UN***

*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.
**Benefits are assessed at the global level, not the service level (refer to HEDIS MY 2024 Volume 2: Technical Specifications for Health Plans, General Guideline: Required Benefits).
***NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

Table A-8—MHN's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Effectiveness of Care Domain: Prevention and Screening		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		
BMI Percentile Documentation—Total	48.18% ★	R
Counseling for Nutrition—Total	38.20% ★	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Counseling for Physical Activity—Total	38.20% ★	R
Childhood Immunization Status (CIS)		
Combination 3	59.82% ★	R
Combination 7	51.96% ★	R
Combination 10	25.38% ★★	R
Immunizations for Adolescents (IMA)		
Combination 1 (Meningococcal, Tdap)	84.67% ★★★	R
Combination 2 (Meningococcal, Tdap, HPV)	31.42% ★★	R
Lead Screening in Children (LSC)		
Lead Screening in Children	53.78% ★	R
Cervical Cancer Screening (CCS)		
Cervical Cancer Screening	38.20% ★	R
Chlamydia Screening in Women (CHL)		
Ages 16 to 20 Years	32.88% ★	R
Ages 21 to 24 Years	44.47% ★	R
Total	37.80% ★	R
Effectiveness of Care Domain: Respiratory Conditions		
Appropriate Testing for Pharyngitis (CWP)		
Ages 3 to 17 Years	84.63% ★★	R
Ages 18 to 64 Years	79.05% ★★★	R
Ages 65 Years and Older	NA	R
Total	83.34% ★★	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	66.29% ★★	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Bronchodilator	75.84% ★	R
Asthma Medication Ratio (AMR)		
Ages 5 to 11 Years	NA	R
Ages 12 to 18 Years	NA	R
Ages 19 to 50 Years	NA	R
Ages 51 to 64 Years	NA	R
Total	NA	R
Effectiveness of Care Domain: Cardiovascular Conditions		
Controlling High Blood Pressure (CBP)		
Controlling High Blood Pressure (<140/90 mm Hg)	17.27% ★	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)		
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	R
Effectiveness of Care Domain: Diabetes		
Glycemic Status Assessment for Patients With Diabetes (GSD)		
Glycemic Status <8.0%	22.14% ★	R
*Glycemic Status >9.0%**	73.24% ★	R
Blood Pressure Control for Patients With Diabetes (BPD)		
Blood Pressure <140/90 mm Hg	10.26% ★	R
Eye Exam for Patients With Diabetes (EED)		
Eye Exam	47.93% ★	R
Effectiveness of Care Domain: Behavioral Health		
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	62.24% ★★	R
Effective Continuation Phase Treatment	48.95% ★★★	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
7-Day Follow-Up—Ages 6 to 17 Years	52.36% ★★★	R
30-Day Follow-Up—Ages 6 to 17 Years	76.01% ★★★	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
7-Day Follow-Up—Ages 18 to 64 Years	33.93% ★★	R
30-Day Follow-Up—Ages 18 to 64 Years	53.08% ★★	R
7-Day Follow-Up—Ages 65 Years and Older	NA	R
30-Day Follow-Up—Ages 65 Years and Older	NA	R
7-Day Follow-Up—Total	37.99% ★★	R
30-Day Follow-Up—Total	58.09% ★★	R
Follow-Up After ED Visit for Mental Illness (FUM)		
7-Day Follow-Up—Total	34.63% ★★	R
30-Day Follow-Up—Total	55.12% ★★	R
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)		
7-Day Follow-Up—Total	27.31% ★★	R
30-Day Follow-Up—Total	45.51% ★★	R
Follow-Up After ED Visit for Substance Use (FUA)		
7 -Day Follow-Up—Total	23.85% ★★	R
30-Day Follow-Up—Total	38.22% ★★	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	81.23% ★★	R
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)		
Diabetes Monitoring for People With Diabetes and Schizophrenia	59.14% ★	R
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	R
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.83% ★★	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Effectiveness of Care Domain: Overuse/Appropriateness		
Appropriate Treatment for Upper Respiratory Infection (URI)		
Ages 3 Months to 17 Years	90.14% ★★	R
Ages 18 to 64 Years	80.88% ★★★	R
Ages 65 Years and Older	NA	R
Total	88.21% ★★	R
Use of Imaging Studies for Low Back Pain (LBP)		
Ages 18 to 64 Years	64.78% ★	R
Ages 65 to 75 Years	NA	R
Total	64.96% ★	R
Use of Opioids at High Dosage (HDO)		
*Use of Opioids at High Dosage (Average Morphine Milligram Equivalents [MME] ≥ 90)**	1.36% ★★★	R
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)		
Ages 3 Months to 17 Years	80.58% ★★★★	R
Ages 18 to 64 Years	40.14% ★★	R
Ages 65 Years and Older	NA	R
Total	67.32% ★★★	R
Access/Availability of Care Domain		
Initiation and Engagement of SUD Treatment (IET)		
Initiation of SUD Treatment—Total—Ages 13 to 17 Years	30.59% ★	R
Engagement of SUD Treatment—Total—Ages 13 to 17 Years	15.29% ★★★	R
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	39.66% ★	R
Engagement of SUD Treatment—Total—Ages 18 to 64 Years	12.41% ★★	R
Initiation of SUD Treatment—Total—Ages 65 Years and Older	NA	R
Engagement of SUD Treatment—Total—Ages 65 Years and Older	NA	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Initiation of SUD Treatment—Total—Total	38.83% ★	R
Engagement of SUD Treatment—Total—Total	12.73% ★★	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	85.64% ★★	R
Postpartum Care	72.51% ★	R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)		
Ages 1 to 11 Years	53.85% ★★	R
Ages 12 to 17 Years	58.33% ★★	R
Total	56.45% ★★	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	NA	R
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	NA	R
Child and Adolescent Well-Care Visits (WCV)		
Ages 3 to 11 Years	51.29% ★	R
Ages 12 to 17 Years	54.62% ★★	R
Ages 18 to 21 Years	24.32% ★	R
Total	49.17% ★	R
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization		
Plan All-Cause Readmissions (PCR)		
Observed Readmissions—Ages 18–64 Years	25.00% ★	R
Expected Readmissions—Ages 18–64 Years	8.99% NC	R
Observed/Expected Ratio—Ages 18–64 Years	2.7804 ★	R

HEDIS Measures	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Measures Reported Using ECDS		
Breast Cancer Screening (BCS-E)		
Breast Cancer Screening	NA	R
Colorectal Cancer Screening (COL-E)		
Ages 46 to 50 Years	NA	R
Ages 51 to 75 Years	NA	R
Total	NA	R
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)		
Initiation Phase	NA	R
Continuation and Maintenance Phase	NA	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)		
Blood Glucose Testing—Ages 1 to 11 Years	34.76% ★	R
Blood Glucose Testing—Ages 12 to 17 Years	60.80% ★★	R
Blood Glucose Testing—Total	50.56% ★	R
Cholesterol Testing—Ages 1 to 11 Years	25.71% ★	R
Cholesterol Testing—Ages 12 to 17 Years	32.41% ★	R
Cholesterol Testing—Total	29.78% ★	R
Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years	22.86% ★	R
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years	31.48% ★	R
Blood Glucose and Cholesterol Testing—Total	28.09% ★	R
Prenatal Depression Screening and Follow-Up (PND-E)		
Depression Screening	0.00% ★	R
Follow-Up on Positive Screen	NA	R
Postpartum Depression Screening and Follow-Up (PDS-E)		
Depression Screening	0.00% ★	R
Follow-Up on Positive Screen	NA	R

* 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 2024 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
HEDIS MY 2024 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. **MHN**'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 **MHN**'s unvalidated Core Set measure rates in this report.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table A-9 for each activity. This table highlights the extent to which **MHN** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **MHN** can best address opportunities identified for each activity.

Table A-9—MHN Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PMV		
+	**Strength:** The *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* measure indicator was a strength for **MHN** in MY 2024. The MCO ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on this indicator. **MHN**'s rate on the *IMA—Combination 1 (Meningococcal, Tdap)* indicator demonstrates that adolescents 13 years of age were receiving immunizations to help protect them against a potential life-threatening disease.	
+	**Strength:** The *Appropriate Testing for Pharyngitis (CWP)—Ages 18 to 64 Years* measure indicator was a strength for **MHN** in MY 2024. The MCO ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on this indicator. **MHN**'s rate on the *CWP—Ages 18 to 64 Years* indicator demonstrates that providers associated with the MCO were appropriately prescribing antibiotics and ordering a group A streptococcus test for pharyngitis episodes.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment* measure indicator was a strength for **MHN** in MY 2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on this indicator. **MHN**'s rate on the *AMM—Effective Continuation Phase Treatment* indicator demonstrates that the MCO was 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.	
+	**Strength:** The *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 6 to 17 Years, 30-Day Follow-Up—Ages 6 to 17 Years* measure indicators were a strength for **MHN** in MY 2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on these indicators. **MHN**'s rates on the *FUH—7-Day Follow-Up—Ages 6 to 17 Years* and *30-Day Follow-Up—Ages 6 to 17 Years* measure indicators demonstrate that the MCO was effective in ensuring the members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of rehospitalization.	
+	**Strength:** The *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years* measure indicator was a strength for **MHN** in MY2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **MHN**'s rate on the *URI—Ages 18 to 64 Years* indicator demonstrates that the MCO effectively prevented or minimized the prescribing of antibiotics to treat adult members diagnosed with a URI.	
+	**Strength:** The *Use of Opioids at High Dosage (HDO)* measure was a strength for **MHN** in MY2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **MHN**'s rate on the *HDO* measure demonstrates that the MCO effectively prevented or minimized the prescribing of opioids at a dosage of ≥90 mg morphine equivalent dose.	
+	**Strength:** The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years* and *Total* measure indicators were a strength for **MHN** in MY2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **MHN**'s rates on the *AAB—Ages 3 Months to 17 Years* and *Total* indicators demonstrates that the MCO effectively prevented or minimized the	

Strength/ Opportunity for Improvement	Description	Domain(s)
	prescribing of antibiotics to treat child members diagnosed with bronchitis or bronchiolitis.	
+	**Strength:** The *Initiation and Engagement of SUD Treatment (IET)—Engagement of SUD Treatment—Total—Ages 13 to 17 Years* measure indicator was a strength for **MHN** in MY 2024. **MHN** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **MHN**'s rate on the *IET—Engagement of SUD Treatment—Total —Ages 13 to 17 Years* indicator demonstrates that the MCO effectively engaged young members with a new SUD episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total*, *Counseling for Nutrition—Total*, *Counseling for Physical Activity—Total* measure indicators. **Recommendations:** Monitoring the weight of children and adolescents can reduce the risk for obesity and prevent adverse health outcomes. HSAG recommends that **MHN** 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.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Childhood Immunization Status (CIS)—Combination 3*, *Combination 7* measure indicators. **Recommendations:** The timely immunization of children ensures they are protected against preventable diseases that are potentially life-threatening. HSAG recommends that **MHN** and its providers educate members about the benefits of childhood immunizations and deploy interventions to encourage adult members to vaccinate their young children.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Lead Screening in Children (LSC)* measure. **Recommendations:** Screening for lead is an easy way to detect an abnormal blood lead level in children. HSAG recommends that **MHN** educate members about the benefits of lead screening and work with its providers to utilize PCP visits to test young children for lead exposure.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Cervical Cancer Screening (CCS)* measure. **Recommendations:** Screening adult women for cervical cancer facilitates the early detection and treatment of one of the most common causes of cancer deaths for American Women.[18] HSAG recommends that **MHN** encourage its providers to conduct regular follow-ups with adolescent and adult female members, through various modes of communication, to ensure members return for cervical cancer screenings.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years* and *Total* measure indicators. **Recommendations:** 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). HSAG recommends that **MHN** encourage its providers to conduct regular follow-ups with adolescent and adult female members, through various modes of communication, to ensure members return for chlamydia screenings.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* measure indicator. **Recommendations:** Timely follow-up with adult members who had an acute inpatient stay or ED visit due to COPD exacerbation is necessary to ensure the appropriate management of this chronic condition. HSAG recommends that **MHN** determine whether its providers facilitate timely follow-up visits for members that experienced a COPD exacerbation and communicate with members about the importance of COPD medication adherence.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Controlling High Blood Pressure (CBP)* measure.	

[18] American Cancer Society. 2020. "Key Statistics for Cervical Cancer." https://www.cancer.org/cancer/types/cervical-cancer/about/key-statistics.html

Strength/ Opportunity for Improvement	Description	Domain(s)
	Recommendations: Controlling high blood pressure significantly reduces the risks of cardiovascular disease mortality and leads to better health outcomes. HSAG recommends that **MHN** work with its providers to identify and implement strategies to help members better manage their blood pressure.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status <8.0%* and *Glycemic Status >9.0* measure indicators. **Recommendations:** Early detection and management of diabetes can prevent a variety of health complications, including heart disease, blindness, and kidney failure. HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to better assess and manage members with diabetes.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure. **Recommendations:** Early detection and management of diabetes can prevent a variety of health complications, including heart disease, blindness, and kidney failure. HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to better monitor health complications associated with diabetes, such as high blood pressure.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Eye Exam for Patients With Diabetes (EED)* measure. **Recommendations:** Early detection and management of diabetes can prevent a variety of health complications, including heart disease, blindness, and kidney failure. HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to better monitor health complications associated with diabetes, such as retinal disease.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)* measure. **Recommendations:** Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. HSAG recommends that **MHN** develop and implement interventions to	

Strength/ Opportunity for Improvement	Description	Domain(s)
	encourage and incentivize its providers to screen members on antipsychotic medications for diabetes, in order to ensure adequate diabetes management for this population.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Use of Imaging Studies for Low Back Pain (LBP)—Ages 18 to 64 Years* and *Total* measure indicators. **Recommendations:** Clinical guidelines for treating patients with low back pain strongly recommend against the use of imaging in the absence of evidence of serious underlying issues such as a fracture or tumor.[19] HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to minimize the use of imaging to evaluate low back pain in enrolled adult members.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years*, *Initiation of SUD Treatment—Total—Ages 18 to 64 Years*, and *Initiation of SUD Treatment—Total—Total* measure indicators. **Recommendations:** Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs. HSAG recommends that **MHN** work with its providers to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Prenatal and Postpartum Care (PPC)—Postpartum Care* measure indicator. **Recommendations:** HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to improve the quality and accessibility of postpartum care. **MHN** could also consider using incentives to encourage members to engage in postpartum care services.	
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators.	

[19] Downie, A., et al. 2013. "Red Flags to Screen for Malignancy and Fracture in Patients with Low Back Pain: Systematic Review." BMJ 347:f7095. doi: 10.1136/bmj.f7095.

Strength/ Opportunity for Improvement	Description	Domain(s)
	Recommendations: Well-care visits provide an opportunity for providers to provide screening and counseling. HSAG recommends that **MHN** work with its providers to implement targeted interventions to ensure members receive timely and medically-appropriate well-care services.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Ages 18–64 Years* and *Observed/Expected Ratio—Ages 18–64 Years* measure indicators. **Recommendations:** 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 **MHN** work with its providers to ensure diagnosis and treatment of members are complete and precise to improve readmission rates.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)—Blood Glucose Testing—Ages 1 to 11 Years*, *Blood Glucose Testing—Total*, *Cholesterol Testing—Ages 1 to 11 Years*, *Cholesterol Testing—Ages 12 to 17 Years*, *Cholesterol Testing—Total*, *Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years*, *Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years*, and *Blood Glucose and Cholesterol Testing—Total* measure indicators. **Recommendations:** Children and adolescents on antipsychotic medications are at increased risk for metabolic health complications. HSAG recommends that **MHN** work with its providers to establish new or bolster existing interventions to ensure that child and adolescent members prescribed antipsychotic medications receive continuous blood glucose and cholesterol testing to enable metabolic monitoring and prevent adverse health events.	
−	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Prenatal Depression Screening and Follow-Up (PND-E)—Depression Screening* measure indicator. **Recommendations:** HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to perform a depression screening during prenatal care visits.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: MHN** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Postpartum Depression Screening and Follow-Up (PDS-E)—Depression Screening* measure indicator. **Recommendations:** HSAG recommends that **MHN** develop and implement interventions to encourage and incentivize its providers to perform a depression screening during postpartum care visits.	

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since **MHN** began operations on January 1, 2024, last year's report did not include such an evaluation for this MCO.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table A-10—Compliance With Regulations—Trended Performance for MHN

Standard and Applicable Review Years*	Year One (CY 2022–2023)**	Year Two (CY 2023–2024)**	Year Three (CY 2024–2025)**	Year Four (CY 2025–2026)**
Standard Number and Title	**MHN Results**			
Standard I—Enrollment and Disenrollment				100%
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				89%
Standard VI—Coordination and Continuity of Care			100%	
Standard VII—Coverage and Authorization of Services			84.2%	
Standard VIII—Provider Selection and Program Integrity				89%
Standard IX—Subcontractual Relationships and Delegation				100%
Standard X—Practice Guidelines			100%	
Standard XI—Health Information Systems				100%
Standard XII—Quality Assessment and Performance Improvement				100%
Standard XIII—Grievance and Appeal System			92.0%	

* Bold text indicates standards that HSAG reviewed during CY 2025–2026.

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

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table A-11 for each activity. This table highlights the extent to which **MHN** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **MHN** can best address opportunities identified for each activity.

Table A-11—MHN Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
Assessment of Compliance With Medicaid Managed Care Regulations		
+	**Strength: MHN** 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.	
+	**Strength:** Four out of six standards met 100 percent compliance and identified no required actions.	
+	**Strength: MHN** achieved full compliance for the Enrollment and Disenrollment standard, demonstrating nondiscriminatory enrollment and contractually compliance disenrollment processes under MLTC oversight.	
+	**Strength: MHN** achieved full compliance for the Subcontractual Relationships and Delegation standard, demonstrating **MHN** had proper oversight and management with contracted vendors.	
+	**Strength: MHN** achieved full compliance with the Health Information Systems standard, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements.	
+	**Strength: MHN** achieved full compliance with the QAPI standard, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; MLTC-approved PIPs; and timely reporting to MLTC.	
−	**Opportunity for Improvement: MHN**'s policies and procedures included the requirement to establish a process to monitor and reduce the appointment no-show rate by provider and service type to include primary care dentists. However, **MHN** stated that the process had not yet been implemented and will start 7/1/2025, and it will include collecting data and tracking visits to identify trends, root causes, and the development of remediation plans. **Recommendations: MHN** must implement the process to monitor and reduce the appointment no-show rate by provider and service type.	
−	**Opportunity for Improvement: MHN**'s policies and procedures included that **MHN** establishes mechanisms to ensure compliance with timely access to care and services standards by network provider. Additionally, the policies included the monitoring of network providers regularly to determine compliance. However,	

Strength/ Opportunity for Improvement	Description	Domain(s)
	MHN staff members stated during the interview session that the process to take corrective action if there is a failure to comply by a network provider had not been implemented. **Recommendations: MHN** must implement the corrective action process if there is failure to comply with timely access to care and services standards by a network provider.	
–	**Opportunity for Improvement:** During the review period, **MHN** did not have written policies and procedures that included the retention of network providers. **MHN** submitted a revision to the Considerations for Network policy that included the strategies **MHN** uses to retain providers. **Recommendations: MHN** must submit the revised policy as part of the corrective action process to HSAG.	
–	**Opportunity for Improvement: MHN**'s policy and procedure included information that the MCO confirms that the provider has been reviewed and approved by an accrediting body. The policy and procedure also stated that the provider must have a CMS or State review completed in the last three years. During the file review, one recredentialing file identified a delegate had utilized a site visit that was over three years old. **Recommendations: MHN** must ensure that delegated entities providing recredentialing of organizations' services on behalf of **MHN** are following **MHN**'s policy that the provider have a CMS or State review completed in the last three years.	
–	**Opportunity for Improvement: MHN** was unable to provide documentation of information that included this requirement found in 42 CFR §438.606 and in the MLTC contract: • The documentation or information the MCO submits to MLTC is certified by the MCO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. **Recommendations: MHN** must develop a policy and procedure or standard operating procedure to include the following requirement: • The documentation or information the MCO submits to MLTC is certified by the MCO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or	

Strength/ Opportunity for Improvement	Description	Domain(s)
	Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.	
−	**Opportunity for Improvement:** **MHN**'s policy and procedure included that the MCO, and all applicable subcontractors, issues a notice of payment suspension. However, during the interview session, **MHN** staff members stated that during the compliance review period **MHN** was not sending the payment suspension notice. **Recommendations:** **MHN** must develop a template for payment suspension notices, and issue the notices according to the requirement and following its policy and procedure.	

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

Table A-12 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table A-12—Follow-Up on Prior Year's Recommendations for Compliance Review

Recommendation
MHN 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: Molina Healthcare of Nebraska has reviewed the compliance monitoring report and implemented corrective actions aligned with the recommendations. The Advance Directives Policy and Procedure has been reviewed and remains up to date. Members and their representatives receive written information regarding Advance Directives upon enrollment or upon request. Additionally, Molina members may access information about Advance Directives through our Member Services team, Case Management, or directly via the Molina website.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Improved documentation and member awareness regarding Advance Directives have been observed through member interactions and case management outreach. Member feedback indicates an increased understanding of their right to receive information about treatment options and care preferences**.**
Identify any barriers to implementing initiatives: No barriers were identified. Ongoing monitoring ensures continued compliance with state and federal requirements.

Identify strategy for continued improvement or overcoming identified barriers:

Molina will continue to monitor compliance through internal audits, staff training, and periodic policy review to ensure ongoing alignment with NCQA and DHHS requirements. The Member Services and Case Management teams will reinforce education during new member onboarding and outreach calls.

HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation

MHN received a score of 66.7 percent for the Member Rights and Confidentiality standard**.** As a result, HSAG recommended that **MHN** 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.

Response

Describe initiatives implemented based on recommendations:

Molina Healthcare of Nebraska acknowledges the findings and recommendations issued by HSAG regarding the Member Rights and Confidentiality standard.

All member rights and responsibilities, as outlined in the Member Rights and Responsibilities Policy, have been incorporated into the Nebraska Member Handbook on pages 19–20. The handbook reflects the comprehensive list of member rights in accordance with regulatory requirements and Molina's internal policy. Verification can be found at the following link: NE 2025 Member Handbook (English).

In addition, Molina Healthcare has updated the Member Rights and Responsibilities Policy to ensure full alignment with HSAG's recommendation. Specifically, the recommendation was to revise the policy to read:

"Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand." However, post audit in MLTC's review of the updated policy, Molina was directed to use the specific wording outlined in 482 NAC 7.002.01(B). Accordingly, the Member Rights and Responsibilities Policy was revised to state:

"Be given information about their illness or medical condition; understand the treatment options, risks, and benefits; and make an informed decision about whether they will receive treatment."

Furthermore, information regarding Advance Directives is addressed within the Nebraska Member Handbook on pages 62–63 as well as an Advance Directive Information Sheet available on the NE Materials page: https://www.molinahealthcare.com/members/ne/en-us/-/media/Molina/PublicWebsite/PDF/members/ne/en-us… all reinforcing Molina's commitment to ensuring members are fully informed of their rights and options related to care and treatment decisions.

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

Molina Healthcare of Nebraska, has implemented several targeted initiatives to enhance compliance and member experience related to the Member Rights and Confidentiality standard. As a result, notable performance improvements have been observed in both documentation accuracy and policy alignment.

Specifically, the Member Rights and Responsibilities Policy was reviewed and revised to ensure full alignment with regulatory requirements and the Nebraska Member Handbook. All member rights are now clearly listed and consistently presented across both documents. This initiative has improved internal quality assurance review outcomes and reduced discrepancies identified during policy audits.

Additionally, enhanced collaboration between the Quality, Compliance, and Member Materials teams has strengthened Molina's internal review processes, ensuring timely updates and sustained compliance with member communication standards. These actions have contributed to improved audit readiness and an overall increase in performance within the Member Rights and Confidentiality standard.

Identify any barriers to implementing initiatives:

No barriers were identified.

Identify strategy for continued improvement or overcoming identified barriers:

To ensure ongoing alignment and prevent future discrepancies, the following strategies have been implemented:

1. Ongoing Policy and Document Alignment Reviews:
   Molina will conduct annual reviews of the Member Rights and Responsibilities Policy and the Member Handbook to ensure consistency and compliance with federal, state, and contractual requirements.
2. Enhanced Cross-Departmental Collaboration:
   The Quality, Compliance, and Member Materials teams will continue to collaborate on all member-facing document updates. This coordinated review process ensures that revisions are accurate, complete, and reflective of the most current regulatory standards.

HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation

MHN 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.

Response

Describe initiatives implemented based on recommendations:

Molina has updated the member website to ensure full compliance with accessibility, content, and availability requirements. The updated site now:

- Meets Section 508, Section 504 of the Rehabilitation Act, and W3C Web Content Accessibility Guidelines (WCAG) standards.
- Provides all member materials in a format that is readily accessible, electronically retainable, and printable.
- Includes a prominent notice informing members that all materials are available in paper form at no cost upon request, to be provided within five business days.
- Displays all applicable information in the Member Forms and Materials section of the website, with accessibility and printing guidance clearly presented at the top of the page.
  Verification link: https://molinahealthcare.com/NEMaterials

Accessibility reports have been uploaded to document compliance with these electronic information standards.

Additionally, Molina has updated the *Nebraska Member Handbook* to include all required content related to member rights and available assistance:

- Page 72: Information on Grievance Procedures, including the availability of assistance during the filing
- process.
- Page 73: Information on State Fair Hearings, including the availability of assistance to request a hearing.
- Page 11: Information regarding the MCO's structure and operation, physician incentive plans, service utilization policies, how to report alleged marketing violations, and reports of transactions between the MCO and parties in interest, as defined in Section 1318(h) of the Public Health Service Act.

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

Molina Healthcare of Nebraska has seen clear improvement in how member information is shared and accessed. Updates to the member website now ensure all materials meet accessibility standards, are easy to find, and can be viewed, printed, or saved by members.

The Member Handbook has also been updated to include clear information about grievances, state fair hearings, and how members can access reports or learn more about Molina's structure and operations. These changes make it easier for members to understand their rights and available resources.

As a result, Molina has strengthened compliance with state and federal requirements, improved the quality of member materials, and increased readiness for future audits.

Identify any barriers to implementing initiatives:

No Barriers were identified.

Identify strategy for continued improvement or overcoming identified barriers:

Going forward, Molina will implement the following:

1. Regular Accessibility Reviews:
   The Growth and Community Engagement team, in collaboration with Compliance and appropriate internal teams, will conduct semiannual reviews of the Member Website and materials to ensure continued compliance with Section 508, Section 504, and WCAG accessibility standards.
2. Content Alignment and Quality Checks:
   These teams will maintain a coordinated review process to confirm that all online and printed materials remain current, accurate, and fully aligned with state and federal regulatory requirements.

HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
For the Emergency and Poststabilization Services standard, HSAG recommended that **MHN** 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.
Response
Describe initiatives implemented based on recommendations: The MHI-HCS 302 and MHI-HCS 302.01 Emergency and Post-Stabilization Services Policy and Procedure are in place, and the Emergency and Post-Stabilization Services standard is being followed by the MCO.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable at this time.
Identify any barriers to implementing initiatives: No barriers have been identified.
Identify strategy for continued improvement or overcoming identified barriers: Molina will ensure that all contractual requirements continue to be clearly reflected within relevant policies and procedures.
HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
MHN 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, **MHN** 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, **MHN**'s NABD must be in writing and meet the language and format requirements of 42 CFR §438.10(c).

Response
Describe initiatives implemented based on recommendations: The HCS-325.01 Service Authorization procedure includes language requiring notice to be given five calendar days before the date of action when probable member fraud has been verified. The HCS 325 and 325.01 Addendum now includes provisions for extending the timeframe for making standard or expedited authorization decisions by up to 14 additional calendar days if the member or provider requests an extension, or if the MCO justifies the need for additional information and demonstrates that the extension is in the member's best interest. Additional language was also added to the addendum to address NABD timeframes, including the requirement that the NABD must be in writing and meet all language and format requirements in accordance with 42 CFR §438.10(c).
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The HCS 325 and 325.01 Policy, Procedure, and Addendum are now aligned with contractual and federal requirements.
Identify any barriers to implementing initiatives: No barriers have been identified. Staff are adhering to the HCS 325 and 325.01 Policy, Procedure, and Addendum.
Identify strategy for continued improvement or overcoming identified barriers: No barriers identified; no further improvement strategies are needed at this time.
HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
MHN received a score of 92.0 percent for the Grievance and Appeal System. As a result, **MHN** 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, **MHN**'s appeal resolution notices must be in writing and meet the language and format requirements of 42 CFR §438.10.
Response
Describe initiatives implemented based on recommendations: The Appeals and Grievances team conducts daily reviews of incoming appeals and monitors each case by age to ensure compliance with the 10-calendar-day written acknowledgment requirement. Designated staff responsible for processing appeals received targeted training and tools to ensure resolution notices meet the language and format standards outlined in 42 CFR §438.10. To reinforce training and ensure sustained compliance, a post-training monitoring process was implemented: • From April 28, 2025, through May 31, 2025, all appeal resolution letters were reviewed by the Appeals and Grievances Manager prior to mailing to verify adherence to language and format requirements. • Beginning July 2025, a minimum of 10% of all appeals resolved in the prior month are audited to confirm ongoing compliance.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
Identify any barriers to implementing initiatives: No barriers have been identified.
HSAG Assessment: **MHN** sufficiently addressed the CY 2024–2025 recommendation.

Validation of Network Adequacy

Results

Findings on the Information Systems Capabilities Assessment

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

- HSAG evaluated the information systems data processing procedures and personnel that **MHN** had in place to support network adequacy indicator reporting. HSAG identified no concerns with **MHN**'s information systems data processing procedures and personnel.
- HSAG evaluated the information systems and processes used by **MHN** 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 **MHN**'s enrollment data capture, data processing, data integration, data storage, or data reporting.
- HSAG evaluated the information systems and processes used by **MHN** to capture provider data as well as **MHN**'s provider data system(s). HSAG identified no concerns with **MHN**'s 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 **MHN** requiring corrective action during the time frame in scope of the NAV audit. HSAG identified no concerns with **MHN**'s network adequacy indicator results or reporting processes.

Overall, HSAG determined that **MHN**'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 **MHN** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table A-13 summarizes HSAG's validation ratings for **MHN** by indicator type, with **MHN** receiving *High Confidence* for all access and availability and time and distance indicators.

Table A-13—Summary of MHN'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 from the member's residence.

Table A-14 displays the percentage of **MHN**'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-14–Percentage of MHN Members With Required Access to Care by Provider Category and Urbanicity

Provider Category	Percent 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	100.0%
Oncology-Hematology	99.7%^
Orthopedics	100.0%
Pharmacy, Urban	96.6%
Pharmacy, Rural	91.9%
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	>99.9%^
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	99.8%^
Hospitals	99.1%^
Optometry, Urban	95.2%^
Optometry, Rural	85.3%^
Optometry, Frontier	76.3%^

Provider Category	Percent of Members With Required Access*
Ophthalmology, Urban	97.6%^
Ophthalmology, Rural	>99.9%^
Ophthalmology, Frontier	87.5%^
Dental	
Dentist, Urban	>99.9%^
Dentist, Rural	99.9%^
Dentist, Frontier	100.0%
Dental Specialists	
Oral Surgeon, Urban	73.9%^
Oral Surgeon, Rural	57.1%^
Oral Surgeon, Frontier	18.0%^
Orthodontist, Urban	82.2%^
Orthodontist, Rural	50.7%^
Orthodontist, Frontier	79.1%
Periodontist, Urban	59.0%^
Periodontist, Rural	18.6%^
Periodontist, Frontier	0.0%^
Endodontist, Urban	59.0%^
Endodontist, Rural	18.6%^
Endodontist, Frontier	0.0%^
Prosthodontist, Urban	59.0%^
Prosthodontist, Rural	19.3%^
Prosthodontist, Frontier	0.0%^
Pediadontist, Urban	96.7%
Pediadontist, Rural	83.5%
Pediadontist, Frontier	84.6%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type, in a specific urbanicity. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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 geographic network distribution analysis.
***DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties. Urban results are included for informational purposes.

Table A-15 displays the percentage of **MHN**'s members with the access to care required by contract standards for behavioral health provider categories by Behavioral Health Region.

Table A-15–Percentage of MHN Members With Required Access to Behavioral Health Services by Type of Service and Behavioral Health Region

Provider Category	Percent 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	99.6%^
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. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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-16 identifies the counties where HSAG identified that **MHN** did not meet the minimum geographic access standards in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table A-16–Counties Not Meeting Geographic Access Standard by Provider Category for MHN

Provider Category	Counties Not Meeting Standard*
High-Volume Specialists†**	
Cardiology	Cherry, Dundy
Oncology-Hematology	Boyd, Brown, Cherry, Grant, Keya Paha, Rock
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Platte, Scotts Bluff
Rural	Boone, Burt, Cherry, Custer, Nance, Thayer
Frontier	Hooker, Thomas

Provider Category	Counties Not Meeting Standard*
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Thomas
Region 2	Lincoln, Thomas
Region 4	Cherry
Hospitals**	
Hospitals	Adams, Arthur, Banner, Blaine, Box Butte, Buffalo, Cherry, Clay, Custer, Dawes, Frontier, Garden, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Rock, Scotts Bluff, 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	Buffalo, Dawson, Gage, Lincoln, Madison, Platte
Rural	Dawes
Frontier	Sheridan
Dental	
Dentist, Urban	Gage
Dentist, Rural	Cherry, Cheyenne
Dental Specialists	
Oral Surgeon, Urban	Dawson, Gage, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Oral Surgeon, Rural	Antelope, Boone, Box Butte, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nance, Pawnee, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Stanton, 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, Dawson, Hall, Madison, Platte
Orthodontist, Rural	Antelope, Boone, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, Hamilton, Harlan, Holt, Howard, Kearney, Knox, Merrick, Nance, Nuckolls, Phelps, Pierce, Polk, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster
Orthodontist, Frontier	Boyd, Brown, Garfield, Greeley, Keya Paha, Rock, Sheridan, Sherman, Wheeler

Provider Category	Counties Not Meeting Standard*
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, 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, 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
Endodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Endodontist, Rural	Antelope, Boone, Box Butte, 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, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Endodontist, 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
Prosthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Prosthodontist, Rural	Antelope, Boone, Box Butte, 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, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Prosthodontist, 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
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Furnas, Holt, Red Willow, Richardson, 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 geographic network distribution analysis.

Approved County Exceptions

As part of network monitoring and reporting, each MCO had the opportunity to identify provider categories for which it failed to meet specified minimum geographic access standards. All three MCOs completed and submitted Network Adequacy Exceptions reports to DHHS for review and approval, including reasons for each exception requested. As part of the NAV data collection process, DHHS provided HSAG with the approved MCO exceptions applicable to this measurement period.

As part of NAV, HSAG reviewed the approved exceptions for each MCO and compared against provider categories for which the MCO did not meet the established network standard.

Table A-17 displays the counties for which **MHN** received an approval exception by applicable geographic access standard and provider category.

Table A-17—Approved County Exceptions for MHN

Provider Category	Counties With Approved Exception*
PCP	
Urban	Lincoln
Rural	Cherry
High-Volume Specialists†**	
Cardiology	Cherry
Neurology	Boyd
Oncology-Hematology	Cherry
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Platte, Scotts Bluff
Rural	Cherry, Custer
Frontier	Hooker
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Box Butte, Boyd, Buffalo, Cedar, Cherry, Custer, Dawes, Dundy, Frontier, Furnas, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Optometry	
Urban	Adams, Buffalo, Lincoln, Madison, Platte
Rural	Cherry, Keith
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln, Madison, Platte
Rural	Custer, Furnas, Red Willow, Valley
Dental Specialists	
Oral Surgeon, Urban	Dawson, Gage, Lincoln, Madison, Platte, Scotts Bluff

Provider Category	Counties With Approved Exception*
Oral Surgeon, Rural	Antelope, Boone, Box Butte, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nance, Pawnee, Pierce, Red Willow, Richardson, Stanton, 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, Dawson, Hall, Platte
Orthodontist, Rural	Antelope, Boone, Cedar, Cherry, Clay, Cuming, Custer, Dixon, Hamilton, Harlan, Holt, Howard, Kearney, Knox, Merrick, Nance, Nuckolls, Phelps, Pierce, Polk, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster
Orthodontist, Frontier	Boyd, Brown, Garfield, Greeley, Keya Paha, McPherson, Rock, Sherman, Wheeler
Periodontist, Urban	All Urban Counties
Periodontist, Rural	All Rural Counties
Periodontist, Frontier	All Frontier Counties
Endodontist, Urban	All Urban Counties
Endodontist, Rural	All Rural Counties
Endodontist, Frontier	All Frontier Counties
Prosthodontist, Urban	Adams, Dakota, Dawson, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Prosthodontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Johnson, Kearney, Keith, Knox, Merrick, Nance, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Prosthodontist, Frontier	All Frontier Counties
Pediadontist, Urban	Dakota
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Furnas, Holt, Red Willow, Richardson, Valley
Pediadontist, Frontier	Boyd, Brown, Keya Paha, Rock, Sheridan

*Results are shown only for those provider types for which at least one county had an exception request approved. Note that "all counties" refers to all counties designated by Nebraska as a specific urbanicity. There are 14 urban counties, 48 rural counties, or 31 frontier counties.
**The standard for this provider category does not differ by urbanicity.
†High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Network Capacity Analysis

Table A-18 displays the statewide network capacity analysis results for **MHN** (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-18–MHN Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	6,264	1:19
High-Volume Specialists**		
Cardiology	328	1:354
Neurology	434	1:268
OB/GYN	350	1:111
Oncology-Hematology	176	1:660
Orthopedics	282	1:412
Pharmacy	457	1:254
All Behavioral Health Inpatient and Residential Service Providers	35	1:3,316
All Behavioral Health Outpatient Assessment and Treatment Providers	5,706	1:21
Hospitals	126	1:922
Optometry	109	1:1,065
Ophthalmology	110	1:1,056
Dental		
Dentist	325	1:358
Dental Specialists		
Oral Surgeon	11	1:10,551
Orthodontist	13	1:8,928
Periodontist	1	1:116,059
Endodontist	1	1:116,059
Prosthodontist	2	1:58,030
Pediadontist	68	1:853

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 cases of OB/GYNs (where the member population was limited to females aged 15 years of age and older) and Pediadontists (where the member population was limited to members aged 18 and under).
** High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution 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-19 displays the statewide average travel times (in minutes) and travel distances (in miles) to the first- and second-nearest providers for **MHN** members.

Table A-19—MHN 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**		
Cardiology	9.7 / 8.2	9.8 / 8.4
Neurology	9.1 / 7.7	11.7 / 10.1
OB/GYN	8.1 / 7.0	10.2 / 8.7
Oncology-Hematology	9.3 / 7.8	11.4 / 9.6
Orthopedics	6.5 / 5.4	7.9 / 6.7
Pharmacy	2.6 / 2.2	4.9 / 4.2
All Behavioral Health Inpatient and Residential Service Providers	19.4 / 17.1	36.5 / 31.9
All Behavioral Health Outpatient Assessment and Treatment Providers	2.5 / 2.2	2.9 / 2.5
Hospitals	5.9 / 4.8	13.3 / 11.0
Optometry	11.8 / 10.0	14.0 / 12.0
Ophthalmology	9.3 / 7.9	11.3 / 9.6
Dental		
Dentist	6.0 / 5.2	8.0 / 6.9
Dental Specialists		
Oral Surgeon	46.5 / 40.9	70.2 / 62.1
Orthodontist	34.9 / 28.6	50.3 / 40.4
Periodontist	111.7 / 76.3	— / —
Endodontist	111.7 / 76.3	— / —
Prosthodontist	109.8 / 75.1	112.0 / 76.4
Pediadontist	15.3 / 13.1	18.8 / 16.1

*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 geographic network distribution analysis.
— Indicates that no second provider was available.

Table A-20 provides a comparison of **MHN**'s reported results and HSAG's calculated findings for each applicable geographic access standard and provider category.

Table A-20—Comparison Table of Geographic Access Standard Results by Provider Category for MHN

Provider Category	Statewide		Frontier		Rural		Urban	
	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)
PCP	100.0%	>99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	>99.9%
High-Volume Specialists**								
Cardiology^	99.9%	>99.9%	98.9%	100.0%	99.7%	99.9%	100.0%	100.0%
Neurology^	100.0%	>99.9%	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%
OB/GYN^	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncology-Hematology^	99.7%	99.8%	98.9%	100.0%	98.4%	98.7%	100.0%	100.0%
Orthopedics^	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pharmacy	95.8%	96.9%	97.7%	98.5%	91.9%	96.7%	96.6%	96.9%
All Behavioral Health Inpatient and Residential Service Providers†	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	—	—
All Behavioral Health Outpatient Assessment and Treatment Providers	>99.9%	>99.9%	99.8%	99.1%	>99.9%	>99.9%	>99.9%	>99.9%
Hospitals^	99.1%	99.4%	84.1%	90.7%	97.8%	99.2%	99.9%	99.9%
Optometry	93.0%	99.8%	76.3%	100.0%	85.3%	99.6%	95.2%	99.9%
Ophthalmology	97.7%	98.1%	87.5%	99.2%	>99.9%	100.0%	97.6%	97.6%
Dental								
Dentist	>99.9%	100.0%	100.0%	100.0%	99.9%	100.0%	>99.9%	100.0%
Dental Specialists‡								
Oral Surgeon	69.6%	83.0%	18.0%	10.3%	57.1%	65.1%	73.9%	91.1%
Orthodontist	76.8%	78.0%	79.1%	47.2%	50.7%	56.5%	82.2%	84.4%
Periodontist	50.7%	0.0%	0.0%	0.0%	18.6%	0.0%	59.0%	0.0%
Endodontist	50.7%	0.0%	0.0%	0.0%	18.6%	0.0%	59.0%	0.0%
Prosthodontist	50.8%	53.3%	0.0%	0.0%	19.3%	30.3%	59.0%	61.3%
Pediadontist	94.3%	94.4%	84.6%	91.9%	83.5%	83.0%	96.7%	97.0%

* MCO results reflect values submitted to DHHS and HSAG by the MCO, utilizing the template provided to them by DHHS. Results are rounded to the first decimal place. DHHS notes that rates of greater than 99.9 percent are considered to meet the applicable 100 percent standards.
**High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.
^Indicates Provider Categories with only Statewide contractual network standards.
†DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.
— Indicates that no results are available for comparison, as DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.
‡Please note that the MCO does not report results at the urbanicity-level for Dental Specialists. HSAG rolled up Dental Specialists county-level results to report urbanicity-level results.

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

MHN identified network adequacy challenges within rural and frontier areas, and as well as across dental specialist provider types which were corroborated by HSAG's time and distance analysis. Where MHN failed to meet the geographic access standards across dental specialist provider types, HSAG noted a broad range of percent member access. When assessing at the urbanicity level, HSAG's calculated percentage of members with access for dental specialists ranged from 0.0 percent in frontier areas (Periodontist, Endodontist, Prosthodontist) to 82.2 percent in urban areas (Orthodontist). Please recall that the dental specialist geoaccess standards are assessed by urbanicity, though statewide rates are presented for informational purposes. Table A-16 provides an overview of provider categories and urbanicities for which MHN did not meet the geographic access standard, with shading to indicate compliance with the geographic access standard.

Additionally, HSAG identified network adequacy challenges with meeting access standards to optometrists and ophthalmologists across urbanicity, though percent member access varied. Some MHN members did not have access within standards to optometrists (95.2 percent in urban counties, 85.3 percent in rural counties and 76.3 percent in frontier counties had access). Some MHN members did not have access to ophthalmologists within the standard (97.6 percent in urban counties, >99.9 percent in rural counties, and 87.5 percent in frontier counties had access within the standard).

HSAG recommended that MHN continue to explore best practices and incentive programs that other organizations may have used to increase access. In addition, MHN should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed. A list of the specific counties where MHN did not meet standards is provided in Table A-16, and a list of counties wherein MHN had received exceptions is provided in Table A-17.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table A-21 for each activity. This table highlights the extent to which MHN furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how MHN can best address opportunities identified for each activity.

Table A-21—MHN Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength: MHN** demonstrated strength in its provider data management processes by implementing robust validation and verification practices, including standardized data collection, routine	

Strength/ Opportunity for Improvement	Description	Domain(s)
	credentialing every 36 months, and cross-referencing provider information against State and national databases to ensure accuracy, completeness, and compliance.	
+	**Strength: MHN** met the required time and distance standards for PCPs, High-Volume Neurology, High-Volume OB/GYN, High-Volume Orthopedics, Pharmacy, All Behavioral Health Inpatient and Residential Services Providers, and Pediadontists across all urbanicities.	
+	**Strength: MHN** 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 **MHN**'s ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
−	**Opportunity for Improvement: MHN** failed to meet some time and distance standards for High-Volume Cardiology, High-Volume Oncology-Hematology, All Behavioral Health Outpatient Assessment and Treatment Providers, Hospitals, Optometry, Ophthalmology, Dentists, Oral Surgeon, Orthodontist, Periodontist, Endodontist, and Prosthodontist provider categories. **Recommendations:** For the provider categories for which **MHN** did not meet the time and distance standards, HSAG recommends that **MHN** continue to assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify providers in the data using the standard definitions, or other reasons. If the inability to meet the time and distance standard is due to data concerns, **MHN** should ensure all providers are appropriately identified in future data submissions.	

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

Table A-22 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 recommendations. Please note that the responses in this section were provided by the MCO and have not been edited or validated by HSAG.

Table A-22—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendation
MHN 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 **MHN** leverage Quest Analytics to support onboarding and

training with newer staff members using the program.
Response
Describe initiatives implemented based on recommendations: A Network Adequacy Workgroup was established in Feb 2025 with monthly meetings to review gaps, identify trends, as well as to address any staff training needs. Quest training has been provided, along with several ad hoc trainings, as specific questions arise.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): There is greater confidence in using the tool.
Identify any barriers to implementing initiatives: No barriers identified in using the Quest tool.
Identify strategy for continued improvement or overcoming identified barriers: 1. Monthly meetings will continue throughout the term of the contract. 2. Extend the use of Quest reporting to support data integrity validation efforts. Support the above through defined Standard Operating Procedures.
HSAG Assessment: **MHN** appears to have sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
MHN identified network adequacy challenges within rural areas and across dental providers, which were corroborated by HSAG's time and distance analysis. HSAG recommended that **MHN** continue to explore best practices and incentive programs that other organizations may have used to increase access. In addition, **MHN** should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed.
Response
Describe initiatives implemented based on recommendations: Based on HSAG recommendations, as well as in an effort to increase dental access across the Molina Dental Services footprint, the following initiatives were implemented: engaging with MLTC and National Dental Association(NDA) President to assist with encouraging providers to participate, daily reviews of the MLTC Provider Master File to identify new Medicaid provider participation and contractual negotiations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Increased success rate of ensuring all members have a dental home and access to dental care.
Identify any barriers to implementing initiatives: No barriers identified with implementing initiatives.
Identify strategy for continued improvement or overcoming identified barriers: Clearly outlined, and streamlined, the Find a Provider process as it relates to member assistance, and communication, across multiple departments.
HSAG Assessment: HSAG acknowledges **MHN**'s efforts to improve access within rural areas and to dental specialist providers in its network, as well as to improve access to care for members residing in rural areas.

Network Adequacy Dashboard

Summary

The NAV Dashboard and Saturation Analysis components function primarily as visualization tools that operationalize previously documented NAV results. Accordingly, these components do not generate additional independent findings, nor do they introduce new strengths, opportunities for improvement, or recommendations beyond those delineated in the NAV analytic section.

In collaboration with DHHS, HSAG conducted a detailed review of provider classification methodologies to support cross-MCO comparability. Due to limited or variable state guidance regarding provider categorization, HSAG implemented a standardized classification framework to normalize provider groupings across MCO submissions. This approach necessarily diverged from certain MCO-reported classifications but enabled consistent analytic evaluation across entities.

HSAG presented finalized time and distance results to both DHHS and the MCOs via an interactive Tableau dashboard. The dashboard supports stratified analysis through filters for urbanicity, county, and provider category, enabling granular review of compliance with established network adequacy thresholds. These time/distance components represent the only portions of the NAV Dashboard currently validated for dissemination to DHHS.

For provider types and geographic areas in which MCOs did not meet network adequacy standards, HSAG developed an exploratory, DHHS-only saturation analysis. This analysis identified Medicaid-enrolled providers with comparable service profiles who may serve as potential recruitment targets for strengthening MCO networks. This supplementary analysis was designed exclusively to support DHHS' evaluative and strategic planning processes and is not intended for MCO distribution.

The saturation analysis remains in an early developmental phase. Precision, methodological consistency, and applied utility are still under active refinement with DHHS, and the initial year of results is exploratory. Consequently, there are no substantive findings appropriate for external reporting.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, **MHN** did not have prior year's recommendations from the EQRO.

Provider Directory Validation and Secret Shopper Survey

Results

PDV and secret shopper survey results were not final at the time of reporting. Final results from this activity will be included in the CY 2026–2027 EQR Technical Report.

Substantive Findings

HSAG will assess the accuracy of the managed care network information supplied to Heritage Health program members using three sources: (1) the MCOs' provider data files, (2) the MCOs' online provider directories, and (3) secret shopper survey calls to sampled provider locations. Additionally, the secret shopper survey will assess appointment availability and compliance with DHHS' wait time standards.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, **MHN** did not have prior year's recommendations from the EQRO.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

NTC submitted the clinical PIP, *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*, focused on quality, timeliness, and access domains of healthcare for sexually active women through efforts to increase the percentage of women who receive an annual chlamydia screening, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table B-1 summarizes NTC's PIP validation scores.

Table B-1—2025–2026 PIP Validation Results for NTC

PIP Topic	Type of Review[1]	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		
		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]
Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years	Initial Submission	60%	57%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

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 performance indicator data for **NTC**'s *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, which was used to objectively assess for improvement.

Table B-2—Performance Indicator Results for the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N: 1,534 D: 3,850	39.8%					*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **NTC** reported that 39.8 percent of women 16 to 24 years of age who were identified as sexually active had at least one test for chlamydia during the measurement year.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

NTC submitted the nonclinical PIP, *Health Risk Screener Completion in Pregnant Members*, focused on quality and timeliness domains of healthcare for members who are pregnant, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table B-3 summarizes **NTC**'s PIP validation scores.

Table B-3—2025–26 PIP Validation Results for NTC

PIP Topic	Type of Review[1]	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		
		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]
Health Risk Screener Completion in Pregnant Members	Initial Submission	20%	29%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	90%	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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

Overall, 90 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 performance indicator data for **NTC**'s *Health Risk Screener Completion in Pregnant Members* PIP, which was used to objectively assess for improvement.

Table B-4—Performance Indicator Results for the *Health Risk Screener Completion in Pregnant Members* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of **NTC** Medicaid members, ages 16 years or older at date of confirmation of pregnancy or state enrollment, and who are continuously enrolled for at least 21 days following the date of	N: 238	15.9%					*Not Assessed*

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
confirmed pregnancy and have completed the state required Health Risk Screening assessment within the first 21 days of Medicaid MCO enrollment or confirmed pregnancy date within the measurement year of January 1 to December 10.	D: 1,493						

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **NTC** reported that 15.9 percent of **NTC** Medicaid members with a confirmed pregnancy, and who met the population inclusion criteria, completed the state-required Health Risk Screening assessment within 21 days of Medicaid MCO enrollment or confirmed pregnancy date.

Interventions

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

For the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, **NTC** used brainstorming, member and provider input, a 5 Whys root cause analysis, and a fishbone diagram to identify the barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation, and include the barriers and interventions as documented by **NTC**.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

For the *Health Risk Screener Completion in Pregnant Members* PIP, **NTC** used brainstorming, a 5 Whys root cause analysis, and a fishbone diagram to identify the barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation, and include the barriers and interventions as documented by **NTC**.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table B-5 for each activity. This table highlights the extent to which **NTC** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **NTC** can best address opportunities identified for each activity.

Table B-5—NTC Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength: NTC** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP. The MCO used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	
+	**Strength: NTC** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Health Risk Screener Completion in Pregnant Members* PIP. The MCO used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	

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

Table B-6 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 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-6—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendation
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. • 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. • Use Plan-Do-Study-Act (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.

Response

Describe initiatives implemented based on recommendations: 1) The health plan implemented the following PCR initiatives: ADT early identification of members with BH or Substance Abuse diagnosis. Corporate initiative to apply multiple chronic condition flags to be proactive in case management referral process, outreach and support. **2)** The Health Plan Case Management redesigned their processes based on key quality metrics for both physical health and behavioral health populations. This included expansion of the transition of care team for inpatient admissions, creation of an ED utilization team and implementation of First Year of Life program.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): The Health Plan monitored PCR on a bi-weekly basis during MY2024. Throughout MY2024 the plan maintained a 0.9 and 0.95 OE ratio indicating significant improvement throughout the year. No other interventions seemed necessary since improvement remained consistent. In Feb 2025, new risk adjustment calculations were applied based on technical specification updates at the end of year in 2024. The MY2024 data thus increased OE ratio above 1.0.

HEDIS Measures	MY2023	MY2024	Rate Change
Ages 18-64 Observed Rate	11.76	10.73	-1.03
Age 18-64 OE Ratio	1.138	1.1841	+ 0.0461

Identify any barriers to implementing initiatives:

1) The Health Plan monitored PCR on a bi-weekly basis during MY2024. Throughout the year the plan maintained a 0.9 to a 0.95 OE ratio indicating significant improvement throughout the year. No other interventions seemed necessary since improvement remained consistent. In Feb 2025, new risk adjustment calculations were applied to end of year MY2024 data thus increasing OE ratio above 1.0.
2) ADT data does not include all provider sources.
3) Difficulty in reaching members due to poor contact information.

Identify strategy for continued improvement or overcoming identified barriers:

1) Initiated communication to software vendor Inovalon to potentially apply a preview risk adjustment for future measurement years which can support earlier initiative.
2) ADT: Health plan working with ADT vendor (CyncHealth) to improve source provider and member contact information.
3) Continue to work with other sources such as pharmacy member contact information to obtain more current contact information.

HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 recommendations.

Validation of Performance Measures

Results for Information Systems Standards Review

Table B-7 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-7—Summary of Compliance With IS Standards for NTC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 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. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• 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 with the standard for oversight and controls that ensure correct implementation of measures reporting software. • The LO confirmed that NTC had practices in places to promote protection and resiliency of systems and data. • Sufficient 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 care delivery data. • The LO determined that NTC had policies and procedures in place for submitted data that conform with industry standards. • Sufficient 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).	• NTC was compliant with IS Standard M for medical record review 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 2024 FARs Review
• 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.	
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-8 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-8—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***

Audit Finding	Description	Audit Result
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 ECDS).	Unaudited	***UN***

*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.
**Benefits are assessed at the global level, not the service level (refer to HEDIS MY 2024 Volume 2: Technical Specifications for Health Plans, General Guideline: Required Benefits).
***NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

Table B-9—NTC's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Effectiveness of Care Domain: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation—Total	70.80% ★	71.53% ★	75.18% ★	R
Counseling for Nutrition—Total	65.69% ★★	64.96% ★★	63.75% ★	R
Counseling for Physical Activity—Total	67.64% ★★	62.04% ★★	60.58% ★	R
Childhood Immunization Status (CIS)				
Combination 3	71.29% ★★★★	68.61% ★★★	73.72% ★★★★	R
Combination 7	63.26% ★★★★	60.58% ★★★★	67.88% ★★★★★	R
Combination 10	42.82% ★★★★	42.09% ★★★★	41.36% ★★★★★	R
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.35% ★★	74.94% ★★	81.02% ★★	R
Combination 2 (Meningococcal, Tdap, HPV)	27.49% ★	31.14% ★★	34.55% ★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Lead Screening in Children (LSC)				
Lead Screening in Children	68.15% ★★★	69.88% ★★★	71.78% ★★★	R
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	61.80% ★★★★	63.02% ★★★★	66.67% ★★★★	R
Chlamydia Screening in Women (CHL)				
Ages 16 to 20 Years	31.45% ★	30.29% ★	33.92% ★	R
Ages 21 to 24 Years	42.16% ★	44.01% ★	47.86% ★	R
Total	36.07% ★	36.24% ★	39.84% ★	R
Effectiveness of Care Domain: Respiratory Conditions				
Appropriate Testing for Pharyngitis (CWP)				
Ages 3 to 17 Years	69.03% ★	80.49% ★★	82.11% ★★	R
Ages 18 to 64 Years	63.02% ★★	74.30% ★★★	76.56% ★★	R
Ages 65 Years and Older	NA	NA	NA	R
Total	67.15% ★★	78.78% ★★	80.76% ★★	R
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	72.50% ★★★	71.82% ★★★	68.10% ★★	R
Bronchodilator	82.50% ★★	84.53% ★★★	78.57% ★	R
Asthma Medication Ratio (AMR)				
Ages 5 to 11 Years	82.67% ★★★★	80.16% ★★★	70.20% ★★★	R
Ages 12 to 18 Years	74.78% ★★★★	76.67% ★★★★	73.83% ★★★★	R
Ages 19 to 50 Years	72.22% ★★★★★	73.16% ★★★★★	69.47% ★★★★	R
Ages 51 to 64 Years	75.81% ★★★★★	80.83% ★★★★★	75.00% ★★★★	R
Total	75.92% ★★★★★	76.50% ★★★★	71.26% ★★★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Effectiveness of Care Domain: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure (<140/90 mm Hg)	67.64% ★★★★	63.99% ★★	73.24% ★★★★	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
Persistence of Beta-Blocker Treatment After a Heart Attack	87.23% ★★★★	NA	NA	R
Effectiveness of Care Domain: Diabetes				
Glycemic Status Assessment for Patients With Diabetes (GSD)				
Glycemic Status <8.0%	52.07% ★★★★★	60.58% ★★★	62.04% ★★★	R
*Glycemic Status >9.0%**	36.74% ★★★	27.25% ★★★★	28.71% ★★★	R
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure <140/90 mm Hg	69.59% ★★★	76.16% ★★★★	76.64% ★★★★	R
Eye Exam for Patients With Diabetes (EED)				
Eye Exam	58.39% ★★★	56.20% ★★★	63.02% ★★★★	R
Effectiveness of Care Domain: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	62.14% ★★★	62.91% ★★★	60.10% ★★	R
Effective Continuation Phase Treatment	45.37% ★★★	44.41% ★★★	42.24% ★★	R
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Ages 6 to 17 Years	60.04% ★★★★	70.62% ★★★★★	67.83% ★★★★★	R
30-Day Follow-Up—Ages 6 to 17 Years	78.59% ★★★★	84.94% ★★★★★	84.54% ★★★★★	R
7-Day Follow-Up—Ages 18 to 64 Years	35.06% ★★★	45.66% ★★★★	43.62% ★★★★	R
30-Day Follow-Up—Ages 18 to 64 Years	54.78% ★★★	62.15% ★★★	60.02% ★★★	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

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
7-Day Follow-Up—Total	42.09% ★★★	52.15% ★★★★	50.57% ★★★★	R
30-Day Follow-Up—Total	61.43% ★★★	68.10% ★★★	67.05% ★★★	R
Follow-Up After ED Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	39.42% ★★	40.22% ★★★	40.94% ★★	R
30-Day Follow-Up—Total	59.61% ★★★	58.57% ★★★	57.95% ★★★	R
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7-Day Follow-Up—Total	29.56% ★★	26.94% ★★	30.95% ★★	R
30-Day Follow-Up—Total	47.50% ★★	44.08% ★★	50.34% ★★	R
Follow-Up After ED Visit for Substance Use (FUA)				
7 -Day Follow-Up—Total	29.34% ★★★	26.23% ★★★	28.42% ★★★	R
30-Day Follow-Up—Total	43.47% ★★★★	41.65% ★★★	39.82% ★★★	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	79.60% ★★★	84.65% ★★★★	83.95% ★★★	R
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.82% ★	73.74% ★★★	71.59% ★★	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	61.39% ★★★	62.79% ★★★	66.67% ★★	R
Effectiveness of Care Domain: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI)				
Ages 3 Months to 17 Years	89.72% ★	89.12% ★	89.23% ★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Ages 18 to 64 Years	81.86% ★★★	79.21% ★★	80.42% ★★★	R
Ages 65 Years and Older	NA	78.13% ★★★	NA	R
Total	88.04% ★	87.01% ★★	87.21% ★★	R
Use of Imaging Studies for Low Back Pain (LBP)				
Ages 18 to 64 Years	74.09% ★★★	72.01% ★★★	70.48% ★★★	R
Ages 65 to 75 Years	NA	NA	NA	R
Total	74.09% ★★★	71.89% ★★★	70.32% ★★★	R
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage (Average MME ≥ 90)**	2.04% ★★★	1.53% ★★★	1.81% ★★★	R
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
Ages 3 Months to 17 Years	73.33% ★★★	73.63% ★★★	71.66% ★★★	R
Ages 18 to 64 Years	39.39% ★★	36.62% ★	34.77% ★	R
Ages 65 Years and Older	NA	NA	NA	R
Total	63.17% ★★★	63.49% ★★★	58.90% ★★	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% ★	30.14% ★	34.26% ★	R
Engagement of SUD Treatment—Total—Ages 13 to 17 Years	12.25% ★★★	16.90% ★★★★	20.37% ★★★★★	R
Initiation of SUD Treatment—Total—Ages 18 to 64 Years	39.97% ★	36.43% ★	36.94% ★	R
Engagement of SUD Treatment—Total—Ages 18 to 64 Years	12.62% ★★	10.20% ★★	11.48% ★★	R
Initiation of SUD Treatment—Total—Ages 65 Years and Older	NA	NA	NA	R
Engagement of SUD Treatment—Total—Ages 65 Years and Older	NA	NA	NA	R
Initiation of SUD Treatment—Total—Total	38.98% ★	35.85% ★	36.76% ★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Engagement of SUD Treatment—Total—Total	12.57% ★★	10.80% ★★	12.39% ★★	R
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	83.45% ★★	77.62% ★	87.83% ★★★	R
Postpartum Care	79.08% ★★★	76.89% ★★	83.21% ★★★	R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Ages 1 to 11 Years	57.97% ★★★	56.95% ★★	54.33% ★★	R
Ages 12 to 17 Years	55.30% ★★	65.24% ★★★	61.74% ★★	R
Total	56.22% ★★	61.98% ★★★	59.10% ★★	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	67.06% ★★★★	71.10% ★★★★★	70.19% ★★★★	R
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	70.09% ★★★	73.38% ★★★★	74.70% ★★★	R
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	49.40% ★	53.48% ★	53.82% ★	R
Ages 12 to 17 Years	52.79% ★★★	56.42% ★★★	58.04% ★★★	R
Ages 18 to 21 Years	21.56% ★★	26.37% ★★	29.22% ★★	R
Total	46.14% ★★	50.54% ★★	52.22% ★★	R
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Ages 18–64 Years	11.61% NC	11.76% NC	10.73% ★★	R
Expected Readmissions—Ages 18–64 Years	10.83% NC	10.34% NC	9.06% NC	R
Observed/Expected Ratio—Ages 18–64 Years	1.0718 ★	1.1380 ★	1.1841 ★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Measures Reported Using ECDS				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	54.41% ★★★	56.96% ★★★	58.63% ★★★	R
Colorectal Cancer Screening (COL-E)				
Ages 46 to 50 Years	22.25% NC	29.48% NC	33.66% ★★★	R
Ages 51 to 75 Years	36.61% NC	41.29% NC	46.50% ★★★	R
Total	33.47% NC	38.13% NC	43.12% ★★★	R
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)				
Initiation Phase	43.99% NC	47.26% ★★★	46.50% ★★	R
Continuation and Maintenance Phase	54.15% NC	53.98% ★★★	51.20% ★★	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)				
Blood Glucose Testing—Ages 1 to 11 Years	38.62% NC	47.72% ★★★	49.47% ★★★	R
Blood Glucose Testing—Ages 12 to 17 Years	59.46% NC	60.95% ★★	67.09% ★★★	R
Blood Glucose Testing—Total	52.28% NC	56.03% ★★	60.48% ★★★	R
Cholesterol Testing—Ages 1 to 11 Years	24.78% NC	35.12% ★★★	37.43% ★★★	R
Cholesterol Testing—Ages 12 to 17 Years	34.80% NC	39.52% ★★	46.71% ★★★	R
Cholesterol Testing—Total	31.35% NC	37.89% ★★★	43.23% ★★★	R
Blood Glucose and Cholesterol Testing—Ages 1–11 Years	21.61% NC	32.17% ★★★	35.83% ★★★	R
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years	32.53% NC	37.62% ★★	44.94% ★★★	R
Blood Glucose and Cholesterol Testing—Total	28.77% NC	35.59% ★★★	41.52% ★★★	R
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	0.19% ★★	0.61% ★★	1.82% ★	R
Follow-Up on Positive Screen	NA	NA	NA	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	0.11% ★★★	0.43% ★★	1.00% ★	R
Follow-Up on Positive Screen	NA	NA	NA	R

* 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 2024 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
HEDIS MY 2024 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-10—NTC's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate
CMS Adult Core Measures			
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)			
Use of Pharmacotherapy for Opioid Use Disorder—Total (Rate 1)	57.44%	59.02%	57.49%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)			
*Ages 18 to 64**	1.89%	1.79%	1.89%
*Age 65 and Older**	0.00%	0.00%	1.69%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)			
Ages 18 to 64	—	—	1.63%
Age 65 and Older	—	—	1.17%
Concurrent use of Opioids and Benzodiazepines (COB-AD)			
*Ages 18 to 64**	18.43%	19.33%	20.42%
*Age 65 and Older**	16.18%	11.54%	8.57%
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	—	10.13%	9.64%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	—	45.86%	47.06%
LARC—Within 3 Days of Delivery	—	0.83%	0.73%
LARC—Within 90 Days of Delivery	—	17.71%	16.31%

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate
Contraceptive Care—All Women Ages 21 to 44 (CCW-AD)			
Most or Moderately Effective Contraception	—	—	27.59%
LARC	—	—	6.73%
CMS Child Core Measures Set			
Developmental Screening in the First Three Years of Life (DEV-CH)			
Children Who Turned 1 Year	25.89%	27.75%	28.43%
Children Who Turned 2 Years	32.80%	34.16%	37.98%
Children Who Turned 3 Years	28.61%	32.28%	33.83%
Total	29.05%	31.39%	33.28%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)			
Ages 12 to 17	—	—	1.88%
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	1.98%	3.45%	1.04%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	40.48%	58.62%	54.17%
LARC—Within 3 Days of Delivery	1.59%	2.07%	0.00%
LARC—Within 90 Days of Delivery	20.63%	26.9%	25.52%
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)			
Most or Moderately Effective Method of Contraception	28.50%	28.81%	28.05%
LARC	4.70%	5.31%	5.49%
Oral Evaluation, Dental Services (OEV-CH)			
Age Less Than 3	—	—	26.14%
Ages 3 to 5	—	—	57.03%
Ages 6 to 14	—	—	58.22%
Ages 15 to 20	—	—	35.28%
Total	—	—	48.03%
Sealant Receipt on Permanent First Molars (SFM-CH)			
At Least One Sealant	—	—	7.10%
All Four Molars Sealed	—	—	3.85%
Prevention: Topical Fluoride for Children (TFL-CH)			
Dental or Oral Health Services—Ages 1 to 20	—	—	27.19%

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate
Dental Services—Ages 1 to 20	—	—	24.63%
Oral Health Services—Ages 1 to 20	—	—	0.32%

* 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 or the rate was not displayed in the previous year(s).

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table B-11 for each activity. This table highlights the extent to which **NTC** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **NTC** can best address opportunities identified for each activity.

Table B-11—NTC Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PMV		
+	**Strength:** The *Childhood Immunization Status (CIS)—Combination 3*, *Combination 7*, and *Combination 10* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for these indicators. **NTC**'s rates on the *CIS—Combination 3*, *Combination 7*, and *Combination 10* indicators demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease.	
+	**Strength:** The *Lead Screening in Children (LSC)*; measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **NTC**'s rate on the *LSC* measure demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they were maintaining limited exposure to lead.	
+	**Strength:** The *Cervical Cancer Screening (CCS)* measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **NTC**'s rate on the *CCS* measure demonstrates that enrolled members were receiving recommended preventive screenings.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The *Asthma Medication Ratio (AMR)—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 **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on the *AMR* indicators demonstrate that the MCO effectively managed persistent asthma in enrolled members.	
+	**Strength:** The *Controlling High Blood Pressure (CBP)* measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **NTC**'s rates on the *CBP* measure demonstrate that the MCO was effective in helping members manage their blood pressure, reducing their risk for heart disease and stroke.	
+	**Strength:** The *Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status <8.0%* and *Glycemic Status >9.0%* measure indicators were a strength for the **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on the *GSD—Glycemic Status <8.0%* and *Glycemic Status >9.0%* indicators demonstrate that the MCO was effective in helping adult members with diabetes adequately manage their blood sugar levels.	
+	**Strength:** The *Blood Pressure Control for Patients With Diabetes (BPD)* measure was a strength for the **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **NTC**'s rate on the *BPD* measure demonstrates that the MCO was effective in helping adult members with diabetes adequately manage their blood pressure.	
+	**Strength:** The *Eye Exam for Patients With Diabetes (EED)* measure was a strength for the **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **NTC**'s rate on the *EED* measure demonstrates that the MCO was effective in ensuring that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease.	
+	**Strength:** The *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 6 to 17 Years*, *30-Day Follow-Up—Ages 6 to 17 Years*, *7-Day Follow-Up—Ages 18 to 64 Years*, *30-Day Follow-Up—Ages 18 to 64 Years*, *7-Day Follow-Up—Total*, and *30-Day Follow-Up—Total* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on these indicators demonstrate that the	

Strength/ Opportunity for Improvement	Description	Domain(s)
	MCO was effective in ensuring the members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of rehospitalization.	
+	**Strength:** The *Follow-Up After ED Visit for Mental Illness (FUM)—30-Day Follow-Up—Total* measure indicator was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **NTC**'s rate on this indicator demonstrates that the MCO properly managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release.	
+	**Strength:** The *Follow-Up After ED Visit for Substance Use (FUA)—30-Day Follow-Up—Total* measure indicator a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **NTC**'s rate on this indicator demonstrates that the MCO properly managed care for patients discharged after an ED visit for substance use, as they are vulnerable after release.	
+	**Strength:** The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. **NTC**'s rate on the *SSD* measure demonstrates that the MCO was 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.	
+	**Strength:** The *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years* measure indicator was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **NTC**'s rate on the *URI—Ages 18 to 64 Years* indicator demonstrates that the MCO effectively prevented or minimized the prescribing of antibiotics to treat adult members diagnosed with a URI.	
+	**Strength:** The *Use of Imaging Studies for Low Back Pain (LBP)—Ages 18 to 64 Years* and *Ages 65 to 75 Years* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on the *LBP—Ages 18 to 64 Years* and *Ages 65 to 75 Years* indicators demonstrate that the MCO	

Strength/ Opportunity for Improvement	Description	Domain(s)
	prevented or minimized the use of imaging to evaluate adult members with low back pain.	
+	**Strength:** The *Use of Opioids at High Dosage (HDO)* measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **NTC**'s rate on the *HDO* measure demonstrates that the MCO effectively prevented or minimized the prescribing of opioids at a dosage of ≥90 mg morphine equivalent dose.	
+	**Strength:** The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years* measure indicator was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **NTC**'s rate on the *AAB—Ages 3 Months to 17 Years* indicator demonstrates that the MCO effectively prevented or minimized the prescribing of antibiotics to treat child members diagnosed with bronchitis or bronchiolitis.	
+	**Strength:** The *Initiation and Engagement of SUD Treatment (IET)—Engagement of SUD Treatment—Total—Ages 13 to 17 Years* measure indicator was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this indicator. **NTC**'s rate on the *IET—Engagement of SUD Treatment—Total—Ages 13 to 17 Years* indicator demonstrates that the MCO effectively engaged young members with a new SUD episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment.	
+	**Strength:** The *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on the *PPC—Timeliness of Prenatal Care* and *Postpartum Care* indicators demonstrate that the MCO effectively worked with providers to ensure 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.	
+	**Strength:** The *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* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators were a strength for the **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **NTC**'s rates on the *W30—Well-Child Visits in the*	

Strength/ Opportunity for Improvement	Description	Domain(s)
	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* indicators demonstrate that the MCO was effective in ensuring that children were seen by a PCP to assess and influence members' early development.	
+	**Strength:** The *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* measure indicator was a strength for the **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **NTC**'s rate on the *WCV—Ages 12 to 17 Years* indicator demonstrates that the MCO was effective in ensuring that adolescents received appropriate well-care visits to provide screening and counseling.	
+	**Strength:** The *Breast Cancer Screening (BCS-E)* measure was a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on this measure. **NTC**'s rates on the *BCS-E* measure demonstrate that the MCO was 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.	
+	**Strength:** The *Colorectal Cancer Screening (COL-E)—Ages 46 to 50 Years*, *Ages 51 to 75 Years*, and *Total* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on these indicators. **NTC**'s rates on the *COL-E—Ages 46 to 50 Years*, *Ages 51 to 75 Years*, and *Total* indicators demonstrate that the MCO was effective in ensuring that adults 46 to 75 years of age have appropriate and timely screening for colorectal cancer.	
+	**Strength:** The *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)—Blood Glucose Testing—Ages 1 to 11 Years*, *Blood Glucose Testing—Ages 12 to 17 Years*, *Blood Glucose Testing—Total*, *Cholesterol Testing—Ages 1 to 11 Years*, *Cholesterol Testing—Ages 12 to 17 Years*, *Cholesterol Testing—Total*, *Blood Glucose and Cholesterol Testing—Ages 1 to 11 Years*, *Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years*, and *Blood Glucose and Cholesterol Testing—Total* measure indicators were a strength for **NTC** in MY 2024. **NTC** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on these indicators. **NTC**'s rates on the *APM-E* indicators demonstrate that MCO ensured that child and adolescent members prescribed antipsychotic medications receive continuous blood glucose and cholesterol testing to enable metabolic monitoring and prevent adverse health events.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* measure indicators. **Recommendations:** Monitoring the weight of children and adolescents can reduce the risk for obesity and prevent adverse health outcomes. HSAG recommends that **NTC** work with its providers to determine whether children and adolescent members receive a weight assessment and education on healthy habits during visits with a PCP.	
–	**Opportunity for Improvement: NTC** ranked below the QC national Medicaid 25th percentile benchmark for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* indicators. **Recommendations:** Screening adolescent and adult women can help identify chlamydia infections which, if untreated, can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1. HSAG recommends that **NTC** verify whether its providers 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.	
–	**Opportunity for Improvement: NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* measure indicator. **Recommendations:** Timely follow-up with adult members who had an acute inpatient stay or ED visit due to COPD exacerbation is necessary to ensure the appropriate management of this chronic condition. HSAG recommends that **NTC** develop and implement interventions to encourage and incentivize its providers to follow up with members that experienced a COPD exacerbation and communicate the importance of COPD medication adherence.	
–	**Opportunity for Improvement: NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *URI—Ages 3 Months to 17 Years* measure indicator. **Recommendations:** The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommends that **NTC** work with its providers to better understand the circumstances resulting in antibiotic prescribing for URI and	

Strength/ Opportunity for Improvement	Description	Domain(s)
	evaluate noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	
–	**Opportunity for Improvement:** **NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *AAB—Ages 18 to 64 Years* measure indicator. **Recommendations:** The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommends that **NTC** work with its providers to better understand the circumstances resulting in antibiotic prescribing for bronchitis/bronchiolitis and evaluate noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	
–	**Opportunity for Improvement:** **NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years*, *Initiation of SUD Treatment—Total—Ages 18 to 64 Years*, and *Initiation of SUD Treatment—Total—Total* measure indicators. **Recommendations:** Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs. HSAG recommends that **NTC** work with its providers to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment.	
–	**Opportunity for Improvement:** **NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark on the *WCV—Ages 3 to 11 Years* measure indicator. **Recommendations:** Well-care visits provide an opportunity for providers to provide screening and counseling. HSAG recommends that **NTC** work with its providers to implement targeted interventions to ensure members receive timely and medically-appropriate well-care services.	
–	**Opportunity for Improvement:** **NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Prenatal Depression Screening and Follow-Up (PND-E)—Depression Screening* measure indicator. **Recommendations:** HSAG recommends that **NTC** develop and implement interventions to encourage and incentivize its providers to perform a depression screening during prenatal care visits.	
–	**Opportunity for Improvement:** **NTC** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for	

Strength/ Opportunity for Improvement	Description	Domain(s)
	the *Postpartum Depression Screening and Follow-Up (PDS-E)—Depression Screening* measure indicator. **Recommendations:** HSAG recommends that **NTC** develop and implement interventions to encourage and incentivize its providers to perform a depression screening during postpartum care visits.	

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 2024–2025 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 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.
Response
Describe initiatives implemented based on recommendations: **WCC BMI**: In 2024 Nebraska Total Care identified potential mapping issues with select supplemental data files. Fixes to mapping applied in MY2025. Monitoring of files sources continues. Developed provider strategy for education and outreach using Quality Practice Advisors including Pay for Performance, key metrics, measure education and gap list sharing. **WCC Physical Activity**: The Health Plan developed provider strategy which included appropriate documentation education to providers using Quality Practice Advisors. This is shared through Value Based Contracting (VBC); Pay 4 Performance (P4P) meetings and quality meeting updates (education, key metric and gap report list sharing). **WCC –** Nutrition Counseling: Only a nutritionist can provide submission of coding related to this measure. Developed provider strategy which included appropriate documentation. Developed provider strategy which included appropriate level of counseling by dietitian and documentation education to providers using Quality Practice Advisors. This is shared through Value Based Contracting (VBC); Pay 4 Performance (P4P) meetings and quality meeting updates (education, key metric and gap report list sharing) **CHL**: Data Analysis was conducted and found that code 87801 used by Nebraska fee schedule (NAC) is a bundle code for sexually transmitted disease (STD) screening. This code is non-specific to CHL screening thus unable to become and report out as a custom measure by NCQA HEDIS guidance. The bundled code also paid

out at a higher rate. Upon this finding, NE Total Care is conducting year-round chart chase for CHL members with an 87801 claims. Other initiatives included P4P provider incentives and education (newsletters, VBC and P4P meetings and Quality Practice Advisor meetings and correspondence) and member digital messaging campaigns. CHL is a DHHS MLTC and all MCO PIP for 2024-2026.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **WCC- BMI:** Rate of 78.18% showed a YoY (MY23 vs MY24) increase of 3.65% or a 5.10275% percentage change. **WCC-Nutrition Counseling Total:** Rate of 63.75% **s**howed a YoY (MY23 vs MY24) decrease of -1.21% decrease or 1.86268 percentage change. **WCC-Physical Activity**: Rate of 60.58% **s**howed a -1.46% decrease YoY (MY23 vs MY24) which is 2.35332% percentage change. **CHL-ages 16-20:** Rate of 33.92% showed a YoY (MY23 vs MY24) increase by 3.63% or 11.9842% percentage change. **CHL-ages 21-24**: Rate of 47.86% showed a YoY (MY23 vs MY24) increase of 3.85% or 8.74801% percentage change. **CHL-Total**: Rate of 39.84% showed a YoY (MY23 vs MY24) increase of 3.5% or 9.63126% percentage change.
Identify any barriers to implementing initiatives: **WCC- BMI Barrier:** Centene Corporate resource support to assist in analysis and fix. This is also a Hybrid Measure that was impacted by the 'luck of the draw' of the sample population and correct chart submission by provider office. **WCC -Nutrition Counseling:** This is a Hybrid Measure that was impacted by the' luck of the draw' of the sample population and correct chart submission by provider office. Newer NCQA guidance requires Dietitian counseling vs. practitioner which is not being reflected in documentation consistently. **WCC-Physical Activity:** This is a Hybrid Measure that may be impacted by the luck of the draw of the sample population and correct chart submission by provider office.
Identify strategies for continued improvement or overcoming identified barriers: **BMI WCC:** Corporate has added additional data analyst support per health plan's request during the last 2 years to better meet the needs of SDS file analysis. Corporate SDS team and Health Plan meeting weekly to monitor supplemental data streams, review errors and investigate / mitigate other issues. Ongoing monitoring of chart submissions during year-round and hybrid chases to identify provider documentation trends and share accordingly with designated providers. Note – unable to impact random sampling of Hybrid Chase. **WCC Nutrition & Physical Activity:** Ongoing monitoring of chart submissions during year-round & /and hybrid chases to identify provider trends in documentation for discussion with designated providers. Note – unable to impact random sampling of Hybrid Chase. Ongoing education to provider groups on measures, providers required to meet measure and documentation needs. **CHL:** Utilize bundle CHL coding to create a list of members for year-round chart retrieval process. Improve chase logic to identify potential members to ensure privacy related to STD's. Provider discussion related to claims needed to close gaps and obtain P4P, thus submitting claims if managing grant funded clinics. Discuss with providers potential coordination of care issues between pediatrics and OB.
HSAG Assessment: **NTC** implemented interventions to improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total* measure indicator, including the review of additional data sources, additionally analytic support, and provider education. **NTC**'s rate on *WCC—BMI Percentile Documentation—Total* indicator

improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on this indicator.

NTC implemented interventions to improve performance on the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators, including chart review for codes related to STD screening, provider education, and member messaging. **NTC**'s rate on the *CHL—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* indicators improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on these indicators.

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: **URI- 3 mo to 17 yrs**: Reviewed root cause analysis from MY23 with a continued use of nonspecific respiratory diagnosis in MY24. **AAB – 18-64 years**: The percent change of -1.85 is proportional to the changes seen within the national averages. Nebraska Total Care reviewed disparities across age, race, ethnicity, sex and language spoken. Only identified disparity is among those classified as 'unknown' which indicates they did not answer the REL questions. Potential disparity among higher income areas of Omaha.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **URI:** Rate of 89.23% shows a YoY (MY23-MY24) increase by 0.11% or 0.123429% percentage change despite seeing national average decrease of 0.02%. **AAB:** Rate of 34.77% show no noted performance improvement.
Identify any barriers to implementing initiatives: **URI Barriers:** As a health Managed Care Organization, we cannot advise providers how to code. Education has been minimally effective in past. **AAB Barriers:** Further analysis of disparity findings and working to improve REL data.
Identify strategy for continued improvement or overcoming identified barriers: **URI:** Attempt to leverage growing Quality Practice Advisor provider relationships to enhance acceptance of education.

AAB: Continue to work on REL data to better understand any potential disparities within this measure population. In Q4 2024, the member portal was enhanced to ensure secure member submission for REL and SOGI data by members. The plan will continue to monitor for efficacy. Continue with enhanced REL mapping by Data Analytics team.

HSAG Assessment: To improve performance on the *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years* measure indicator, **NTC** conducted root cause analysis and explored options to encourage providers to accept education on coding. **NTC**'s rate on the *URI—Ages 3 Months to 17 Years* indicator improved slightly from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on this indicator.

To understand its performance on the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 18 to 64 Years* measure indicator, **NTC** conducted analyses to uncover potential disparities across key demographic elements. **NTC**'s performance on the *AAB—Ages 18 to 64 Years* indicator did not improve from MY 2023 to MY 2024. HSAG recommends that **NTC** continue efforts to improve performance on this indicator.

Recommendation

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.

Response

Describe initiatives implemented based on recommendations:

IET age 13-17, 18-64 and Total: Based on recommendations, the health plan conducted a root cause analysis finding issues that were negatively impacting the measure denominator. This is specifically related to how the state pays and recommends the use of social detox code. Findings were discussed with the state with no change to fee schedule.

Explored options to improve initial IDI assessment availability which is mandated prior to future treatment for newly diagnosed members.

PPC-Timeliness & Postpartum: Enhanced P4P incentives for Pregnancy Notification & /or EMR prenatal submission. Early notification. Quality Practice Advisors (QPA) engaged providers educating on CPT II coding and Perinatal incentives at Value Based Contracting, P4P meetings and other interaction with provider groups. Provider Email blast on Perinatal Incentives. Provided HEDIS Guide resources for Provider Offices. Member texting and integration into Start Smart for Baby Case Management (CM) program, allowing earlier outreach to

members at risk; Reviewed and investigated provider location for Hybrid Chase list; Continued Member incentive for Notification of pregnancy submission. Most effective initiative was during Hybrid when the health plan reviewed all chart chase member information to locate the correct Perinatal provider location due to poor chart chase logic.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **IET- ages 13-17:** Rate of 34.26% shows a YoY (MY23 -MY24) increase by 4.12% or 13.6695% percentage change. **IET-ages 18-64:** Rate of 34.77% shows a YoY (MY23 -MY24) increase by 0.51% or 1.299995% percentage change. **IET- Total:** Rate of 36.76% shows a YoY (MY23 -MY24) increase by 0.91% or 2.53835% percentage change. **PPC-Timeliness:** Rate 87.83% **s**hows a YoY (MY23 -MY24) increase by 6.51% or 8.00541% percentage change**.** MY 2024 rate (87.93%) above NCQA Quality Compass of 84.87%. **PPC-Postpartum:** Rate of 83.21% **s**hows a YoY (MY23 -MY24) increase by 6.32% or 8.21953% percentage change. MY2024 rate (83.21%) above NCQA Quality Compass of 80.76%.
Identify any barriers to implementing initiatives: **IET**: Barriers include **c**urrent coding practices based on state guidance contradicts the intent of the measures, appropriate identification of 'new' substance abuse diagnosis is needed and correct identification of exclusionary criteria is needed in a timely fashion. **PPC:** Barriers to initiatives include global billing within state for Obstetric care- thus delaying early outreach to members; Many provider offices are not upgrading EMRs to capture CPT II coding; Members are not getting early access into Medicaid or into provider offices; Early hybrid chase list had wrong providers listed due to chase logic issues not capturing correct specialist within Centene HEDIS.
Identify strategy for continued improvement or overcoming identified barriers: **IET:** Expanded identification of substance abuse diagnosis to cast a wider scope of members to initiate outreach. **PPC:** Global Billing – in past few years, the health plan questioned NE DHHS and other state MCO's on removing state global billing for better capturing of maternal health information. At this time, no further action or discussion. CPT II coding- **NTC** will continue to share with providers and encourage CPT II coding for PPC adding appropriate dates of service. Access into Medicaid is being addressed at a statewide level with public messaging on access to Medicaid. The Health Plan directs members to Heritage Health during member events, website information and digital messaging. Hybrid Chase Logic review was trialed in MY2024 Hybrid season and will continue to be used as a best practice for early part of MY2025 Hybrid season project. Parent Organization Centene HEDIS team has also been working on capturing better specialist data into chase logic.
HSAG Assessment: **NTC** implemented interventions to improve performance on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators, including efforts to address issues identified during root cause analysis. **NTC**'s rates on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* indicators improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on this indicator. **NTC** implemented interventions to improve performance on the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure indicator, including outreach and engagement efforts targeting providers and members. **NTC**'s rate on the *PPC—Timeliness of Prenatal Care* indicator improved substantially from MY 2023 to MY 2024, and was at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark.

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: **WCV Initiatives included:** Expansion of member messaging to include emails focusing on First Year of Life Clinical initiative and messaging campaigns and member incentive. Developed provider strategy for education and outreach using Quality Practice Advisors including Pay for Performance (P4P), key metrics, measure education and gap list sharing. The health plan evaluated MY2024 data in relationship to health disparities including race, ethnicity, gender, age, and geographic characteristics. A Health Disparity initiative outreach initiative was created targeting the Arabic population for MY2025.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **WCV- Age 3-11 years:** Rate of 53.82% showed a YoY (MY23 vs MY24) increase by 0.34% or 0.635752% percentage change. **WCV –Total:** Rate of 52.22% showed a YoY (MY23 vs MY24) rate increase by 1.68% or 3.3241% percentage change.
Identify any barriers to implementing initiatives: **WCV ages 3-11 year**: During these years, this population is seen for a 'sports physical' which is not always converted or meets criteria for a wellness visit in the provider office. Many times, schools create a 'Sports Physical event' before activities begin at a reduced cost, separate from PCP. Families may believe that a sports physical meets a wellness visit criteria. Sports physical time frames (if converted into a Wellness Visit) start (per state school association policy) later in May, up until time of the sport activity, thus creating a decrease timeline for completion. Many kids of this age may be going in for illness visits versus wellness checks. This age range can be more challenging to take out of school or hindered by time constraints or transportation issues. Lack of appointment availability or missed appointments can also be a barrier. Failure of appropriate documentation and coding can also be an issue.
Identify strategies for continued improvement or overcoming identified barriers: The Health Plan has created sports physical communications to members and providers encouraging wellness visits, sharing information on how to convert a sports physical into a wellness visit and sharing to member guardians the importance of wellness visits. Aggressive outreach starts at the beginning of the year by the Quality Practice Advisors to promote P4P provider incentives and engage providers in getting members schedule for visits. Case Management who engages with select member guardians discusses gaps in care and facilitates support with any identified social determinants of health needs. Member incentives are provided along with digital messaging to guardians of members. Work with School systems with embedded clinics on wellness visit initiatives. Continue to evaluate data for health disparities and collaborate within identified populations and communities.
HSAG Assessment: **NTC** implemented interventions to improve performance on the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* measure indicator, including member messaging/outreach, and provider education. **NTC**'s rate on the *WCV—Ages 3 to 11 Years* indicator improved slightly from MY 2023 to

MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on this indicator.

Recommendation
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 MY2023 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.
Response
Describe initiatives implemented based on recommendations: Nebraska Total Care recognizes the importance of transition of care in improving member outcomes and keeping members out of the hospitals and emergency departments. In MY2024 and into MY2025 the health plan expanded the Transition of Care (TOC) team, engaged in emergency departments and adjusted focus of the CM team to engage in members with higher utilization, complex care and / or high dollar cases. Areas impacted by this CM redesign included behavioral health, physical health, emergency department and First Year of Life initiatives. **Behavioral Health:** The Health Plan expanded a TOC team from 1.5 – 3 FTE's. The role was expanded beyond 7 days to fully case manage the first 30 days. The dedicated 2 behavioral health CM roles work as Complex Care Managers. Monthly meetings occur with hospital leadership to review complex members and difficult to discharge members. A dedicated Transportation Liaison is also in place to support members and staff. **Physical Health:** For Physical Health Inpatient, a dedicated staff focuses on member outreach post discharge and conducts TOC assessment to identify needs. In person hospital visits coordinate with the TOC Physical Health team. The dedicated 2 Physical Health TOC CM roles work as Complex Care Manager. They take direct referrals from face-to-face team and post hospital outreach team. Monthly meetings are established with the value based contracting provider partners to review members with readmission concerns or difficult to discharge. **Emergency Department:** The Population Health team created a dedicated ED utilization team which is visibly working with select ED's working with staff and members to conduct outreach and engage in assessments. Routine meetings occur between hospital staff and leadership and CM leadership at the health plan to look at high utilizers and create action plans. Dedicated therapists support FUA and FUM HEDIS Measures. **First Year of Life:** This clinical program from parent company, Centene includes presently digital campaigns with focused messaging on wellness visits for those members in the first 15 months of life. The messaging focuses on wellness visits, vaccinations and monitoring of growth milestones. **Metrics:** The metrics being evaluated will include member outreach contacts after discharge, readmission rates, TOC and BH HEDIS assessments.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **PCR Observed Rate- Total:** MY2024 Rate of 10.73% shows a YoY (MY23 -MY24) decrease by 1.03%. **PCR OE Ratio- Total:** MY2024 Rate of 1.1841 shows a YoY (MY23 -MY24) increase by 0.046. The Health Plan monitored PCR on a bi-weekly basis during MY2024. Throughout MY2024 the plan maintained a 0.9 and 0.95 OE ratio indicating significant improvement throughout the year. No other interventions seemed necessary since improvement remained consistent. In February 2025, new risk adjustment

calculations were applied based on technical specification updates at the end of year in 2024. The MY2024 data thus increased OE ratio above 1.0.
Identify any barriers to implementing initiatives: 1. The Health Plan monitored PCR on a bi-weekly basis during MY2025. Throughout the plan maintained 0.9 to a 0.95 OE ratio indicating significant improvement through the year. In February 2025, new risk adjustment calculations were applied from new technical specifications for end of year MY2024 data thus increasing the ratio above 1.0. 2. Difficulty reaching members due to poor contract information. 3. Challenges in establishing relationships and workflow processes within the ER's/ BH facilities. 4. Ensuring useful and accurate ADT data information and other metrics for outreach.
Identify strategies for continued improvement or overcoming identified barriers: 1) Initiated communication to software vendor Inovalon to potentially apply a preview risk adjustment for future measurement years which can support earlier initiatives. 3) & 2) The health plan utilizes the standing VBC committees that have been established to review the collaboration and discuss challenging cases to better meet the needs of the member and obtain better member communication contacts. 4) & 2) ADT: Health Plan is working with ADT vendor CyncHealth (HIE) to improve source provider and member contact information.
HSAG Assessment: **NTC** implemented interventions to improve performance on the *Plan All-Cause Readmissions (PCR)—Observed/Expected Ratio—Total* measure indicator, including efforts to improve care management and care transition, provider engagement, and member engagement. Although, **NTC**'s result on the *PCR—Observed/Expected Ratio—Total* indicator changed slightly from MY 2023 to MY 2024, **NTC** showed improvement relative to the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **NTC** continue efforts to improve performance on this indicator.

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)**	Year Four (CY 2025–2026)**
Standard Number and Title	**NTC Results**			
Standard I—Enrollment and Disenrollment	100%			90%
Standard II—Member Rights and Confidentiality		100%	100%	
Standard III—Member Information		100%	100%	
Standard IV—Emergency and Poststabilization Services	100%		100%	

Standard and Applicable Review Years*	Year One (CY 2022–2023)**	Year Two (CY 2023–2024)**	Year Three (CY 2024–2025)**	Year Four (CY 2025–2026)**
Standard Number and Title	**NTC Results**			
Standard V—Adequate Capacity and Availability of Services		100%		83%
Standard VI—Coordination and Continuity of Care		100%	100%	
Standard VII—Coverage and Authorization of Services		84%	100%	
Standard VIII—Provider Selection and Program Integrity	94%			100%
Standard IX—Subcontractual Relationships and Delegation	75%			86%
Standard X—Practice Guidelines	100%		100%	
Standard XI—Health Information Systems	100%			89%
Standard XII—Quality Assessment and Performance Improvement	100%			100%
Standard XIII—Grievance and Appeal System		100%	92%	

* Bold text indicates standards that HSAG reviewed during CY 2025–2026.
**Grey shading indicates standards for which no comparison results are available.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table B-14 for each activity. This table highlights the extent to which **NTC** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **NTC** can best address opportunities identified for each activity.

Table B-14—NTC Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
Assessment of Compliance With Medicaid Managed Care Regulations		
	Strength: 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	

Strength/ Opportunity for Improvement	Description	Domain(s)
	comprehensive approach to complying with regulations and contract requirements.	
+	**Strength:** Two standards met 100 percent compliance and identified no required actions.	
+	**Strength: NTC** achieved full compliance with the Provider Selection and Program Integrity standard, demonstrating **NTC** had appropriate provider monitoring and processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. **NTC** had developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.	
+	**Strength: NTC** achieved full compliance with the QAPI standard, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; MLTC-approved PIPs; and timely reporting to MLTC.	
−	**Opportunity for Improvement: NTC** did not include in its policy and procedure the federal requirement 42 CFR §438.56(d)(1), which allows for an oral disenrollment request. **Recommendations: NTC** must update its policy to include the federal requirement 42 CFR §438.56(d)(1), which allows for an oral disenrollment request: The member *(or their representative)* must request disenrollment by submitting an oral or written request with cause to the enrollment broker for action by MLTC.	
−	**Opportunity for Improvement: NTC**'s policies and procedures did not include the following time and distance requirements: • The MCO must, at a minimum, contract with: – Two general dentists within 45 miles of the personal residences of members in urban counties. – One general dentist within 60 miles of the personal residences of members in rural counties. – One general dentist within 100 miles of the personal residences of members in frontier counties. • The MCO must, at a minimum, contract with the following dental specialists: – One oral surgeon, one orthodontist, one periodontist, one endodontist, one prosthodontist, and one pediadontist within 45 miles of 85 percent of the personal residences of members in urban counties. – One oral surgeon, one orthodontist, one periodontist, one endodontist, one prosthodontist, and one pediadontist within	

Strength/ Opportunity for Improvement	Description	Domain(s)
	60 miles of 75 percent of the personal residences of members in rural counties. – One oral surgeon, one orthodontist, one periodontist, one endodontist, one prosthodontist, and one pediadontist within 100 miles of 75 percent of the personal residences of members in frontier counties. **Recommendations: NTC** must revise its policies and procedures to ensure its network providers are adequate to serve the expected enrollment in its service area in accordance with MLTC's standards for access to care.	
–	**Opportunity for Improvement: NTC**'s policies and procedures did not include that if changes to the dental wait time and timely access policies and procedures are expected to have a significant impact on the dental provider network or member services, MLTC staff must be notified in writing 30 calendar days before implementation. **Recommendations: NTC** must revise its policies and procedures to include that if changes to the dental wait time and timely access policies and procedures are expected to have a significant impact on the dental provider network or member services, MLTC staff must be notified in writing 30 calendar days before implementation.	
–	**Opportunity for Improvement: NTC**'s policies and procedures did not include the following appointment time requirements: • Urgent care must be: Available the same day and be provided by the PCP or as arranged by the MCO. • Nonurgent sick care must be: Available within 48 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation. • High-volume specialty care, routine appointments must be: Available no later than 30 calendar days of referral. High-volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. • Other specialty care consultation must be: Available no later than one month of referral or as clinically indicated. • Routine or preventative dental services must be provided no later than six (6) weeks of request of service. **Recommendations: NTC** must revise its policies and procedures to ensure its network providers meet DHHS' standards for timely access to care and services, taking into account the urgency of the need for services.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: NTC** did not include in its executed delegated agreements all elements of the federal requirement 42 CFR §438.230(c)(3)(i-iv). HSAG reviewed the following executed agreements: HCA Physicians, Regional West Health System Agreement, and SecureCare Agreement. However, HSAG found no evidence of the federal requirement 42 CFR §438.230(c)(3)(i-iv). **Recommendations: NTC** must update all its executed delegated agreements and templates to include all elements of the federal requirement 42 CFR §438.230(c)(3)(i-iv) to state: • The delegate agrees that— (i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. (ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. (iii) The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	
–	**Opportunity for Improvement: NTC** did not include compliance with the Affordable Care Act, Section 6504(a) and the Affordable Care Act, Section 1903(r)(1)(F) in its policy and procedures. **NTC** did not provide evidence that it complies with Section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by MLTC to meet the requirements of Section 1903(r)(1)(F) of the Affordable Care Act (electronic claims submission). **Recommendations: NTC** must update its policy and procedures to include compliance with the Affordable Care Act, Section 6504(a) and the Affordable Care Act, Section 1903(r)(1)(F). **NTC** must	

Strength/ Opportunity for Improvement	Description	Domain(s)
	include in its policy and procedures: The MCO complies with Section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by MLTC to meet the requirements of Section 1903(r)(1)(F) of the Affordable Care Act (electronic claims submission).	

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

Table B-15 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 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-15—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): Review of the compliance monitoring report, along with its detailed findings and recommendations, has contributed to strengthening our overall compliance posture. This has led to reduced risk exposure and increased stakeholder confidence in our consistent ability to meet regulatory and contractual obligations.
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 2024–2025 recommendation.

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: Page 75 of the member handbook informs members that they may contact Member Services to file a grievance and are instructed to "Give it to us in person or by mail" with the notation "ATTN: Grievances." Member Services staff are trained to assist members with the grievance process. Additionally, on page 91, the handbook reiterates that Nebraska Total Care is available to support members in filing a grievance. To further assist, the following language has been added to page 76 and is currently pending annual review and approval by MLTC: "To get help with this process, call Member Services. Ask for the grievances department. The phone number is 1-844-385-2192 (TTY 711)."
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: N/A
HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: Nebraska Total Care (NTC) revised its Emergency and Post-Stabilization Services policy (CC.UM.54) in response to HSAG's recommendation. Specific language was added to the policy to explicitly state that if a member receives emergency or post-stabilization services from an out-of-network provider, the member will not be charged more than they would have been if the services were rendered by an in-network provider. This aligns with 42 CFR § 438.114 and ensures compliance with federal requirements. The policy update reflects the operational processes in the claims department to ensure accurate application of member cost-sharing protections.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Improved clarity and consistency in claims adjudication for emergency and post-stabilization services.
Identify any barriers to implementing initiatives: Some out-of-network providers are unfamiliar with the billing limitations and may attempt to balance bill members.

Identify strategy for continued improvement or overcoming identified barriers: Distribute updated billing guidance to out-of-network providers and reinforce contractual obligations where applicable.
HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
For the Coverage and Authorization of Services standard, HSAG recommended that **NTC** allow providers/hospitals time to submit requested clinical information prior to rendering a notice of adverse benefit determination (NABD).
Response
Describe initiatives implemented based on recommendations: Nebraska Total Care (NTC) implemented several initiatives in response to HSAG's recommendation to allow providers/hospitals adequate time to submit requested clinical information prior to issuing an Adverse Benefit Determination (ABD). Specifically: - The Utilization Management (UM) teams were re-educated on the Request for Information (RFI) process, emphasizing the importance of clearly specifying needed clinical information and allowing sufficient time for provider response. - The 14-day extension process was reinforced, including the requirement to notify members in writing of the extension, the reason for the delay, and their right to file a grievance if they disagree with the extension decision. - The extension letter timeframe was updated to reflect the full 14 calendar days, aligning with 42 CFR 438.404 and internal policy CC.UM.05. The policy language was updated to reflect the suggested verbiage and was approved by the Utilization Management Committee on August 1, 2025.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): While formal performance metrics are still being collected post-implementation, initial internal audits indicate: - Improved compliance with regulatory timeframes for standard prior authorization decisions. - Reduction in premature ABDs due to insufficient clinical information. - Increased provider engagement, as evidenced by more timely and complete responses to RFIs.
Identify any barriers to implementing initiatives: - Provider responsiveness: Some providers continue to delay submission of clinical documentation, even after outreach. - System limitations: Automated tracking of RFI outreach and extension notifications is still being optimized in the clinical documentation system. - Staff turnover: Ongoing training is required to ensure new UM staff are fully versed in updated procedures.
Identify strategies for continued improvement or overcoming identified barriers: - Enhanced provider education: NTC will continue outreach and education efforts to reinforce the importance of timely clinical submissions. - System enhancements: Work is underway to improve documentation and tracking capabilities within the UM platform to ensure all outreach and extension notices are logged and auditable. - Ongoing training and audits: Regular refresher training for UM staff and quarterly audits.
HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
For the Practice Guidelines standard, HSAG recommended that **NTC** distinguish practice guidelines from payment policies on its website. The MCO should disseminate providers, members, and potential members access to the adopted dental practice guidelines, Nebraska-specific guidelines, and any other available practice guidelines.
Response
Describe initiatives implemented based on recommendations: Nebraska Total Care (NTC) implemented several initiatives to address HSAG's recommendation to distinguish practice guidelines from payment policies and ensure appropriate dissemination: - The provider website was updated to clearly separate clinical practice guidelines from payment policies. This distinction is evident on the Clinical & Payment Policies page, where practice guidelines and payment policies are listed under separate headings. - Dental clinical guidelines are now accessible via Centene Dental's Clinical Policies page, which is linked from NTC's website. - The Dental Provider Resources page on the NTC website includes payment information and directs users to additional clinical resources. - Secure provider and member portals offer access to practice guidelines and resources, ensuring both transparency and accessibility.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): - Improved provider navigation and access to clinical guidelines, reducing confusion between clinical and administrative policies. - Positive feedback regarding the clarity of resource organization.
Identify any barriers to implementing initiatives: NA
Identify strategies for continued improvement or overcoming identified barriers: Ongoing provider education through newsletters, webinars, and direct outreach to highlight clinical practice guidelines and payment policies.
HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
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.

Response
Describe initiatives implemented based on recommendations: Nebraska Total Care conducted a root cause analysis of the appeals work process and identified the need for revisions. This included enhancing staff training on the updated procedures, ensuring staff understanding, and providing access to Microsoft 365 readability statistics to support compliance with language and formatting standards.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Improved staff comprehension of the overall appeals process, along with continued support to ensure adherence to compliance requirements.
Identify any barriers to implementing initiatives: NA
Identify strategy for continued improvement or overcoming identified barriers: Continual monitoring of appeal processing, along with daily utilization of Microsoft 365 readability statistics, to maintain support for compliance requirements.
HSAG Assessment: **NTC** sufficiently addressed the CY 2024–2025 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 delegated entity network adequacy data-related items requiring corrective action during the time frame in scope of the NAV audit. 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-16 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-16—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, optometrists, and ophthalmologists for which the standard is defined in terms of a maximum travel time from the member's residence.

Table B-17 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-17–Percentage of NTC Members With Required Access to Care by Provider Type and Urbanicity

Provider Category	Percent of Members With Required Access*
PCP, Urban	100.0%
PCP, Rural	>99.9%^
PCP, Frontier	100.0%
High-Volume Specialists**	
Cardiology	100.0%
Neurology	100.0%
OB/GYN	100.0%
Oncology-Hematology	99.8%^
Orthopedics	100.0%
Pharmacy, Urban	95.8%

Provider Category	Percent of Members With Required Access*
Pharmacy, Rural	91.4%
Pharmacy, Frontier	97.5%
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	99.9%^
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	97.7%^
Hospitals	99.4%^
Optometry, Urban	>99.9%^
Optometry, Rural	>99.9%^
Optometry, Frontier	100.0%
Ophthalmology, Urban	98.0%^
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	92.9%
Oral Surgeon, Rural	78.7%
Oral Surgeon, Frontier	55.2%^
Orthodontist, Urban	84.7%^
Orthodontist, Rural	67.6%^
Orthodontist, Frontier	100.0%
Periodontist, Urban	23.6%^
Periodontist, Rural	29.3%^
Periodontist, Frontier	0.0%^
Endodontist, Urban	72.7%^
Endodontist, Rural	33.5%^
Endodontist, Frontier	0.0%^
Prosthodontist, Urban	51.7%^
Prosthodontist, Rural	18.3%^
Prosthodontist, Frontier	0.0%^
Pediadontist, Urban	97.5%
Pediadontist, Rural	79.5%

Provider Category	Percent of Members With Required Access*
Pediadontist, Frontier	85.4%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type, in a specific urbanicity. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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 geographic network distribution analysis.
***DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties. Urban results are included for informational purposes.

Table B-18 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-18–Percentage of NTC Members With Required Access to Behavioral Health Services by Type of Service and by Behavioral Health Region

Provider Category	Percent 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	98.6%^
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. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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-19 identifies the counties where HSAG identified that **NTC** did not meet the minimum geographic access standards in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table B-19–Counties Not Meeting Geographic Access Standard by Provider Category for NTC

Provider Category	Counties Not Meeting Standard*
PCP	
Rural	Cherry
High-Volume Specialists†**	
Oncology-Hematology	Cherry, Grant
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Cherry, Clay, Custer, Nance
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	Arthur, Banner, Blaine, Box Butte, Brown, Buffalo, Cherry, Custer, Dawes, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Optometry	
Urban	Lincoln
Rural	Cherry
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln
Dental	
Dentist, Rural	Cherry
Dental Specialists	
Oral Surgeon, Urban	Dawson, Lincoln, Scotts Bluff
Oral Surgeon, Rural	Box Butte, Cherry, Cheyenne, Furnas, Holt, Keith, Knox, Red Willow, Richardson, Thayer
Oral Surgeon, Frontier	Arthur, Banner, Chase, Deuel, Dundy, Garden, Grant, Hayes, Hitchcock, Hooker, Kimball, McPherson, Morrill, Perkins, Sioux, Thomas
Orthodontist, Urban	Adams, Dakota, Gage, Hall, Madison, Platte
Orthodontist, Rural	Antelope, Cedar, Cherry, Clay, Dixon, Hamilton, Holt, Jefferson, Knox, Merrick, Nance, Nuckolls, Pawnee, Pierce, Richardson, Stanton, Thayer, Wayne, Webster

Provider Category	Counties Not Meeting Standard*
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Douglas, Gage, Hall, Lincoln, Madison, Platte, Sarpy, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, Burt, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Washington, Wayne, Webster
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
Endodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Endodontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster
Endodontist, 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
Prosthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lancaster, Lincoln, Madison, Platte, Scotts Bluff
Prosthodontist, Rural	Antelope, Boone, Box Butte, 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, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Seward, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Prosthodontist, 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
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Dixon, Furnas, Holt, Knox, Red Willow, Richardson, Valley
Pediadontist, Frontier	Boyd, Brown, 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 geographic network distribution analysis.

Approved County Exceptions

As part of network monitoring and reporting, each MCO had the opportunity to identify provider categories for which it failed to meet specified minimum geographic access standards. All three MCOs completed and submitted Network Adequacy Exceptions reports to DHHS for review and approval, including reasons for each exception requested. As part of the NAV data collection process, DHHS provided HSAG with the approved MCO exceptions applicable to this measurement period.

As part of NAV, HSAG reviewed the approved exceptions for each MCO and compared against provider categories for which the MCO did not meet the established network standard.

Table B-20 displays the counties for which **NTC** received approval for exception by applicable geographic access standard and provider category.

Table B-20—Approved County Exceptions for NTC

Provider Category	Counties With Approved Exception*
High-Volume Specialists†**	
Cardiology	Cherry
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Madison, Scotts Bluff
Rural	Cherry, Clay, Custer, Knox, Nance, Thurston
Frontier	Hooker, Thomas
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Dundy, Grant, Hooker, Thomas
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Box Butte, Brown, Buffalo, Cedar, Cherry, Custer, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln
Dental Specialists	
Oral Surgeon, Urban	Dawson, Lincoln, Madison, Scotts Bluff
Oral Surgeon, Rural	Antelope, Box Butte, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Keith, Knox, Pierce, Red Willow, Richardson, Stanton, Thayer, Valley
Oral Surgeon, Frontier	Arthur, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Gosper, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, McPherson, Perkins, Rock, Sheridan, Sioux, Thomas

Provider Category	Counties With Approved Exception*
Orthodontist, Urban	Adams, Dakota, Hall
Orthodontist, Rural	Antelope, Cedar, Cherry, Clay, Dixon, Hamilton, Holt, Knox, Merrick, Nuckolls, Pierce, Richardson, Wayne, Webster
Orthodontist, Frontier	Franklin, Keya Paha
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Douglas, Hall, Lincoln, Madison, Platte, Sarpy, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, Burt, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Washington, Wayne, Webster, York
Periodontist, Frontier	All Frontier Counties
Endodontist, Urban	Adams, Buffalo, Dakota, Dawson, Hall, Lincoln, Madison, Platte, Scotts Bluff
Endodontist, Rural	Antelope, Boone, Box Butte, 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
Endodontist, Frontier	All Frontier Counties
Pediadontist, Urban	Dakota
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Furnas, Holt, Red Willow, Richardson, Valley
Pediadontist, Frontier	Boyd, Brown, Chase, Keya Paha, Rock, Sheridan

*Results are shown only for those provider types for which at least one county had an exception request approved. Note that "all counties" refers to all counties designated by Nebraska as a specific urbanicity. There are 14 urban counties, 48 rural counties, or 31 frontier counties.
**The standard for this provider category does not differ by urbanicity.
†High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Network Capacity Analysis

Table B-21 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-21—NTC Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	4,048	1:29
High-Volume Specialists**		
Cardiology	687	1:167
Neurology	620	1:185
OB/GYN	478	1:85
Oncology-Hematology	272	1:422
Orthopedics	677	1:170
Pharmacy	475	1:242
All Behavioral Health Inpatient and Residential Service Providers	80	1:1,433
All Behavioral Health Outpatient Assessment and Treatment Providers	3,824	1:30
Hospitals	240	1:478
Optometry	341	1:337
Ophthalmology	128	1:896
Dental		
Dentist	397	1:289
Dental Specialists		
Oral Surgeon	41	1:2,795
Orthodontist	16	1:7,162
Periodontist	1	1:114,583
Endodontist	2	1:57,292
Prosthodontist	1	1:114,583
Pediadontist	50	1:1,203

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 aged 15 years of age and older, and Pediadontists, where the member population was limited to members aged 18 and under.
** High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution 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-22 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-22—NTC Members' Average Time and Distance to the Nearest First and Second Provider

Provider Category	First Nearest* Time (Min.) Dist. (Mi.)	Second Nearest* Time (Min.) Dist. (Mi.)
PCP	1.9 / 1.6	2.1 / 1.8
High-Volume Specialists**		
Cardiology	6.4 / 5.5	7.7 / 6.6
Neurology	6.5 / 5.6	8.3 / 7.1
OB/GYN	6.1 / 5.3	8.7 / 7.7
Oncology-Hematology	8.1 / 6.8	11.0 / 9.4
Orthopedics	4.6 / 3.8	5.6 / 4.6
Pharmacy	2.8 / 2.3	5.2 / 4.5
All Behavioral Health Inpatient and Residential Service Providers	12.7 / 11.1	17.5 / 15.3
All Behavioral Health Outpatient Assessment and Treatment Providers	2.6 / 2.3	3.5 / 3.0
Hospitals	4.4 / 3.6	5.9 / 4.8
Optometry	4.3 / 3.6	5.4 / 4.6
Ophthalmology	7.8 / 6.6	9.4 / 8.0
Dental		
Dentist	4.7 / 4.0	7.0 / 6.1
Dental Specialists		
Oral Surgeon	21.0 / 18.3	24.3 / 21.3
Orthodontist	24.8 / 20.9	38.3 / 31.7
Periodontist	127.2 / 83.4	— / —
Endodontist	90.1 / 63.1	122.1 / 83.5
Prosthodontist	92.7 / 82.9	121.2 / 83.1
Pediadontist	16.9 / 14.6	21.2 / 18.3

*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 geographic network distribution analysis.

Table B-23 provides a comparison of **NTC**'s reported results and HSAG's calculated findings for each applicable geographic access standard and provider category.

Table B-23—Comparison Table of Geographic Access Standard Results by Provider Category for NTC

Provider Category	Statewide		Frontier		Rural		Urban	
	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)
PCP	>99.9%	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%	100.0%
High-Volume Specialists**								
*Cardiology^*	100.0%	>99.9%	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
*Neurology^*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
*OB/GYN^*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
*Oncology-Hematology^*	99.8%	100.0%	99.7%	100.0%	98.8%	100.0%	100.0%	100.0%
*Orthopedics^*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pharmacy	95.0%	94.5%	97.5%	97.8%	91.4%	87.8%	95.8%	96.0%
All Behavioral Health Inpatient and Residential Service Providers†	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	—	—
All Behavioral Health Outpatient Assessment and Treatment Providers	99.9%	99.9%	97.7%	98.0%	99.9%	>99.9%	>99.9%	>99.9%
Hospitals^	99.4%	99.2%	83.5%	83.6%	99.6%	98.4%	99.9%	99.9%
Optometry	>99.9%	96.2%	100.0%	90.7%	>99.9%	92.7%	>99.9%	97.2%
Ophthalmology	98.4%	98.4%	100.0%	100.0%	100.0%	100.0%	98.0%	98.0%
Dental								
Dentist	>99.9%	>99.9%	100.0%	100.0%	>99.9%	>99.9%	100.0%	100.0%
Dental Specialists‡								
Oral Surgeon	89.3%	81.3%	55.2%	41.8%	78.7%	64.6%	92.9%	86.6%
Orthodontist	81.9%	66.2%	100.0%	100.0%	67.6%	57.6%	84.7%	67.1%
Periodontist	24.1%	22.9%	0.0%	0.0%	29.3%	23.1%	23.6%	23.6%
Endodontist	63.5%	44.4%	0.0%	0.0%	33.5%	20.0%	72.7%	51.6%
Prosthodontist	44.1%	44.0%	0.0%	0.0%	18.3%	18.1%	51.7%	51.6%
Pediadontist	93.9%	95.3%	85.4%	85.4%	79.5%	78.7%	97.5%	99.6%

*MCO results reflect values submitted to DHHS and HSAG by the MCO, utilizing the template provided to them by DHHS. Results are rounded to the first decimal place. DHHS notes that rates of greater than 99.9 percent are considered to meet the applicable 100 percent standards.

**High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

^Indicates Provider Categories with only Statewide contractual network standards.

†DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.

— Indicates that no results are available for comparison, as DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.

‡Please note the MCO does not report results at the urbanicity-level for Dental Specialists. HSAG rolled up Dental Specialists county-level results to report urbanicity-level results.

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

NTC identified network adequacy challenges within rural and frontier areas, as well as across dental specialist providers, which were corroborated by HSAG's time and distance analysis. Where NTC failed to meet the geographic access standards across dental specialist provider types, HSAG noted a broad range of percent member access. When assessing at the urbanicity level, HSAG's calculated percentage of members with access for dental specialists ranged from 0.0 percent in frontier areas (Periodontist, Endodontist, Prosthodontist) to 84.7 percent in urban areas (Orthodontist). Please recall that the dental specialist geoaccess standards are assessed by urbanicity, though statewide rates are presented for informational purposes. Table B-19 provides an overview of provider categories and urbanicities for which NTC did not meet the geographic access standard, with shading to indicate compliance with the geographic access standard.

HSAG recommended that NTC continue to explore best practices and incentive programs that other organizations may have used to increase access. In addition, NTC should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed. A list of the specific counties where NTC did not meet standards is provided in Table B-19, and a list of counties wherein NTC had received exceptions is provided in Table B-20.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table B-24 for each activity. This table highlights the extent to which NTC furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how NTC can best address opportunities identified for each activity.

Table B-24—NTC Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength: NTC** demonstrated an effective parallel processing approach to provider enrollment that allowed credentialing, enrollment, and payment configuration to advance simultaneously. This streamlined process supported the 30-day turnaround requirement and reflected a strong organizational commitment to efficiency, accuracy, and timeliness.	
+	**Strength: NTC** demonstrated strong alignment with State data by requiring all member-reported demographic updates to be routed through the State and reflected back in Unified Member View	

Strength/ Opportunity for Improvement	Description	Domain(s)
	(UMV) via the 834 files, ensuring consistency and minimizing discrepancies across systems.	
+	**Strength: NTC** met the required time and distance standards for High-Volume Cardiology, High-Volume Neurology, High-Volume OB/GYN, High-Volume Orthopedics, Pharmacy, All Behavioral Health Inpatient and Residential Services Providers, and Pediadontists across all urbanicities.	
+	**Strength: 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.	
−	**Opportunity for Improvement: NTC** did not specify a defined time frame for providers to notify the plan of demographic or practice information changes outside of the recredentialing cycle. **Recommendations:** HSAG recommends that **NTC** establish and communicate a protocol requiring providers to report demographic or practice changes (e.g., address, phone, location, or hours of operation) within 30 days of the change to ensure timely updates and improve data accuracy for NAV.	
−	**Opportunity for Improvement: NTC** failed to meet some time and distance standards for PCPs, High-Volume Oncology-Hematology, All Behavioral Health Outpatient Assessment and Treatment Providers, Hospitals, Optometry, Ophthalmology, Dentists, Oral Surgeon, Orthodontist, Periodontist, Endodontist, and Prosthodontist provider categories. **Recommendations:** For the provider categories in which **NTC** did not meet the time and distance standards, HSAG recommends that **NTC** assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, an inability to identify providers in the data using the standard definitions, or other reasons. If an inability to meet the time and distance standard is due to data concerns, **NTC** should ensure all providers are appropriately identified in future data submissions.	

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

Table B-25 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-25—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: The provider data file included 50 unique pediadontists and one periodontist as indicated by the provider category in the ProvCat column. Provider data was pulled in accordance with the guidelines provided by HSAG and reflects the true specialty of the providers as opposed to the services providers can perform. NTC's network of general dentists typically perform pediadontic and periodontic services in the rural and frontier counties where pediadontist specialists and periodontist specialists are typically not available.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
Identify any barriers to implementing initiatives: NA
Identify strategies for continued improvement or overcoming identified barriers: NA
HSAG Assessment: NTC appears to have sufficiently addressed the CY 2024–2025 recommendation. HSAG acknowledges NTC's efforts to maintain and improve access to dental specialist providers in its network.

Recommendation
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 in the Nebraska Contract Year 2024–2025 External Quality Review Technical Report.
Response
Describe initiatives implemented based on recommendations: The network team at Nebraska Total Care has been and will continue to be committed to welcoming opportunities to expand its network of hospitals if or when new hospitals open within the service area.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Nebraska Total Care's hospital network has not materially changed since the MCO's launch in 2017, nor has the opening and closing of hospitals changed, with very few exceptions. As newly enrolled dental providers are identified via the state's Medicaid enrollment file, the team makes outreach to offer them an opportunity to join our network.
Identify any barriers to implementing initiatives: Without the opening of new hospitals in Nebraska, there is limited opportunity to close existing hospital gaps. There are limited dental professionals including specialist available to contract with in rural and frontier areas.

Identify strategy for continued improvement or overcoming identified barriers: Nebraska Total Care will be eager to pursue a participating provider agreement with any new hospitals that join the service area, particularly those that have the potential to close access gaps for members. There are instances when we offer incentives to dental providers to join the network, which may include increases in reimbursement, authorization waivers, etc. It should also be noted that general dentists under their scope of licensure are able to perform the same services as other specialists such periodontal and/or endodontic services. They are also able to support uncomplicated extractions. The same can be said for pediatric dental care. Most often families with children are seen by a general dentist who may refer a child to a pediatric dentist should there be a need for complex treatment.
HSAG Assessment: HSAG acknowledges **NTC**'s efforts to maintain and improve access to hospitals and dental specialist providers in its network.

Network Adequacy Dashboard

Summary

The NAV Dashboard and Saturation Analysis components function primarily as visualization tools that operationalize previously documented NAV results. Accordingly, these components do not generate additional independent findings, nor do they introduce new strengths, opportunities for improvement, or recommendations beyond those delineated in the NAV analytic section.

In collaboration with DHHS, HSAG conducted a detailed review of provider classification methodologies to support cross-MCO comparability. Due to limited or variable state guidance regarding provider categorization, HSAG implemented a standardized classification framework to normalize provider groupings across MCO submissions. This approach necessarily diverged from certain MCO-reported classifications but enabled consistent analytic evaluation across entities.

HSAG presented finalized time and distance results to both DHHS and the MCOs via an interactive Tableau dashboard. The dashboard supports stratified analysis through filters for urbanicity, county, and provider category, enabling granular review of compliance with established network adequacy thresholds. These time/distance components represent the only portions of the NAV Dashboard currently validated for dissemination to DHHS.

For provider types and geographic areas in which MCOs did not meet network adequacy standards, HSAG developed an exploratory, DHHS-only saturation analysis. This analysis identified Medicaid-enrolled providers with comparable service profiles who may serve as potential recruitment targets for strengthening MCO networks. This supplementary analysis was designed exclusively to support DHHS' evaluative and strategic planning processes and is not intended for MCO distribution.

The saturation analysis remains in an early developmental phase. Precision, methodological consistency, and applied utility are still under active refinement with DHHS, and the initial year of results is exploratory. Consequently, there are no substantive findings appropriate for external reporting.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, NTC did not have prior year's recommendations from the EQRO.

Provider Directory Validation and Secret Shopper Survey

Results

PDV and secret shopper survey results were not final at the time of reporting. Final results from this activity will be included in the CY 2026–2027 EQR Technical Report.

Substantive Findings

HSAG will assess the accuracy of the managed care network information supplied to Heritage Health program members using three sources: the MCOs' provider data files, the MCOs' online provider directories, and secret shopper survey calls to sampled provider locations. Additionally, the secret shopper survey will assess appointment availability and compliance with DHHS' wait time standards.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, NTC did not have prior year's recommendations from the EQRO.

Validation of Performance Improvement Projects

Results

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

UHCCP submitted the clinical PIP, *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*, focused on quality, timeliness, and access domains of healthcare for sexually active women through efforts to increase the percentage of women who receive an annual chlamydia screening, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table C-1 summarizes **UHCCP**'s PIP validation scores.

Table C-1—2025–2026 PIP Validation Results for UHCCP

PIP Topic	Type of Review[1]	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		
		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]
Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*The MCO did not resubmit.*					

[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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

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 performance indicator data for **UHCCP**'s *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, which was used to objectively assess for improvement.

Table C-2—Performance Indicator Results for the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N: 1,435 D: 4,069	35.3%					*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **UHCCP** reported that 35.3 percent of women 16–24 years of age who were identified as sexually active had at least one test for chlamydia during the measurement year.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

UHCCP submitted the nonclinical PIP, *Health Risk Screener Completion in Pregnant Members*, focused on quality and timeliness domains of healthcare for members who are pregnant, for the CY 2025–2026 validation cycle. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The second validation rating was *Not Assessed* as the MCO reported baseline data only. Table C-3 summarizes **UHCCP**'s PIP validation scores.

Table C-3—2025–26 PIP Validation Results for UHCCP

PIP Topic	Type of Review[1]	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		
		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]
Health Risk Screener Completion in Pregnant Members	Initial Submission	80%	71%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	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**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

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 performance indicator data for **UHCCP**'s *Health Risk Screener Completion in Pregnant Members* PIP, which was used to objectively assess for improvement.

Table C-4—Performance Indicator Results for the *Health Risk Screener Completion in Pregnant Members* PIP

Performance Indicator	Baseline (01/01/2024 to 12/31/2024)		Remeasurement 1 (01/01/2025 to 12/31/2025)		Remeasurement 2 (01/01/2026 to 12/31/2026)		Sustained Improvement
The percentage of **UHCCP** Nebraska pregnant members who complete the state-required health risk screening within the first 21 calendar days of MCO enrollment or confirmed pregnancy.	N: 30 D: 1,951	1.5%					*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, **UHCCP** reported that 1.5 percent of pregnant members completed the state-required health risk screening within the first 21 calendar days of MCO enrollment or confirmed pregnancy.

Interventions

Clinical PIP: *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years*

For the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP, **UHCCP** used brainstorming, member and provider input, plan-specific data analyses, and a fishbone diagram to identify the barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation and include the barriers and interventions as documented by **UHCCP**.

Nonclinical PIP: *Health Risk Screener Completion in Pregnant Members*

For the *Health Risk Screener Completion in Pregnant Members* PIP, **UHCCP** reported using brainstorming, member and provider input, plan-specific data analyses, and a fishbone diagram to identify the barriers to improving performance indicator outcomes. The MCO will report initial interventions to address identified barriers to improvement for next year's validation, and include the barriers and interventions as documented by **UHCCP**.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table C-5 for each activity. This table highlights the extent to which **UHCCP** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **UHCCP** can best address opportunities identified for each activity.

Table C-5—UHCCP Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength: UHCCP** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years* PIP. The MCO used a methodologically sound PIP design,	

Strength/ Opportunity for Improvement	Description	Domain(s)
	accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	
+	**Strength: UHCCP** received a *High Confidence* rating for adherence to an acceptable methodology for all phases of the *Health Risk Screener Completion in Pregnant Members* PIP. The MCO used a methodologically sound PIP design, accurately reported baseline indicator results, and initiated appropriate QI processes for the PIP.	

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

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

Validation of Performance Measures

Results for Information Systems Standards Review

Table C-6 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-6—Summary of Compliance With IS Standards for UHCCP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 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. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• **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 with the standard for oversight and controls that ensure correct implementation of measure reporting software. • The LO confirmed that **UHCCP** had practices in places to promote protection and resiliency of systems and data.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
	– Sufficient 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. • Sufficient 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.	• **UHCCP** was compliant with IS Standard M for medical record review 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.	• **UHCCP** was compliant with IS Standard A for administrative data. • The LO determined that the MCO appropriately validated the 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 **UHCCP**. According to the DHHS' required data collection methodology, the rates displayed in Table C-7 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-7—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****
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 ECDS).	Unaudited	***UN***

*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.
**Benefits are assessed at the global level, not the service level (refer to HEDIS MY 2024 Volume 2: Technical Specifications for Health Plans, General Guideline: Required Benefits).
***NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

Table C-8—UHCCP's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Effectiveness of Care Domain: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation —Total	68.37% ★	70.56% ★	75.18% ★	R
Counseling for Nutrition—Total	66.67% ★★	55.96% ★	69.34% ★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Counseling for Physical Activity —Total	66.91% ★★	52.07% ★	66.42% ★★	R
Childhood Immunization Status (CIS)				
Combination 3	77.37% ★★★★★	74.45% ★★★★★	77.37% ★★★★★	R
Combination 7	69.10% ★★★★★	66.42% ★★★★★	70.56% ★★★★★	R
Combination 10	53.77% ★★★★★	48.18% ★★★★★	43.55% ★★★★★	R
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	82.00% ★★★	81.02% ★★★	79.81% ★★	R
Combination 2 (Meningococcal, Tdap, HPV)	37.47% ★★★	35.52% ★★★	35.04% ★★	R
Lead Screening in Children (LSC)				
Lead Screening in Children	73.48% ★★★★	70.80% ★★★	79.32% ★★★★	R
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	60.58% ★★★	54.99% ★★	61.07% ★★★	R
Chlamydia Screening in Women (CHL)				
Ages 16 to 20 Years	27.04% ★	26.77% ★	32.25% ★	R
Ages 21 to 24 Years	38.59% ★	38.53% ★	38.71% ★	R
Total	31.90% ★	31.84% ★	35.03% ★	R
Effectiveness of Care Domain: Respiratory Conditions				
Appropriate Testing for Pharyngitis (CWP)				
Ages 3 to 17 Years	69.34% ★	80.98% ★★	82.54% ★★	R
Ages 18 to 64 Years	63.66% ★★	75.70% ★★★	74.37% ★★	R
Ages 65 Years and Older	NA	NA	NA	R
Total	67.52% ★★	79.54% ★★	80.50% ★★	R
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	72.62% ★★★	78.10% ★★★★	74.39% ★★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Bronchodilator	86.43% ★★★	85.16% ★★★	84.63% ★★★	R
Asthma Medication Ratio (AMR)				
Ages 5 to 11 Years	74.43% ★★	76.03% ★★★	71.46% ★★★	R
Ages 12 to 18 Years	74.95% ★★★★	75.83% ★★★★	72.38% ★★★	R
Ages 19 to 50 Years	68.01% ★★★★	69.87% ★★★★	69.03% ★★★★	R
Ages 51 to 64 Years	64.32% ★★★	69.42% ★★★	72.29% ★★★★	R
Total	70.97% ★★★★	72.75% ★★★★	70.84% ★★★★	R
Effectiveness of Care Domain: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure (<140/90 mm Hg)	76.40% ★★★★★	72.51% ★★★★	74.45% ★★★★	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
Persistence of Beta-Blocker Treatment After a Heart Attack	76.92% ★★	NA	NA	R
Effectiveness of Care Domain: Diabetes				
Glycemic Status Assessment for Patients With Diabetes (GSD)				
Glycemic Status <8.0%	60.10% ★★★★★	63.02% ★★★★	67.64% ★★★★★	R
*Glycemic Status >9.0%**	29.44% ★★★★★	29.44% ★★★★	23.11% ★★★★★	R
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure <140/90 mm Hg	76.16% ★★★★★	79.56% ★★★★★	78.59% ★★★★	R
Eye Exam for Patients With Diabetes (EED)				
Eye Exam	65.69% ★★★★★	65.94% ★★★★★	68.86% ★★★★★	R
Effectiveness of Care Domain: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	64.46% ★★★	65.90% ★★★	67.64% ★★★	R
Effective Continuation Phase Treatment	47.48% ★★★	47.79% ★★★	48.63% ★★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Ages 6 to 17 Years	53.06% ★★★	54.46% ★★★	57.21% ★★★	R
30-Day Follow-Up—Ages 6 to 17 Years	76.12% ★★★	77.57% ★★★	80.35% ★★★★	R
7-Day Follow-Up—Ages 18 to 64 Years	38.88% ★★★	41.52% ★★★	43.38% ★★★	R
30-Day Follow-Up—Ages 18 to 64 Years	60.96% ★★★	60.55% ★★★	64.49% ★★★	R
7-Day Follow-Up—Ages 65 Years and Older	NA	13.33% ★	50.00% ★★★★	R
30-Day Follow-Up—Ages 65 Years and Older	NA	46.67% ★★	63.04% ★★★	R
7-Day Follow-Up—Total	42.74% ★★★	44.24% ★★★	46.92% ★★★	R
30-Day Follow-Up—Total	65.04% ★★★	64.52% ★★★	68.30% ★★★	R
Follow-Up After ED Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	37.42% ★★	38.82% ★★★	42.66% ★★★	R
30-Day Follow-Up—Total	59.43% ★★★	60.61% ★★★	62.71% ★★★	R
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7-Day Follow-Up—Total	23.27% ★★	26.61% ★★	28.86% ★★	R
30-Day Follow-Up—Total	43.54% ★★	44.39% ★★	47.54% ★★	R
Follow-Up After ED Visit for Substance Use (FUA)				
7 -Day Follow-Up—Total	31.07% ★★★★	21.57% ★★	26.48% ★★	R
30-Day Follow-Up—Total	48.22% ★★★★	36.20% ★★★	43.15% ★★★	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	82.26% ★★★	82.20% ★★★	83.74% ★★★	R
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	77.41% ★★★★★	75.61% ★★★★	72.06% ★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	80.56% ★★★	77.14% ★★	67.65% ★	R
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.58% ★★★★★	75.08% ★★★★★	78.33% ★★★★★	R
Effectiveness of Care Domain: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI)				
Ages 3 Months to 17 Years	90.71% ★	89.88% ★	89.63% ★	R
Ages 18 to 64 Years	80.97% ★★	79.98% ★★★	81.84% ★★★	R
Ages 65 Years and Older	65.79% ★★	59.32% ★	74.17% ★★★	R
Total	88.58% ★★	87.52% ★★	87.66% ★★	R
Use of Imaging Studies for Low Back Pain (LBP)				
Ages 18 to 64 Years	73.41% ★★★	70.55% ★★★	72.15% ★★★	R
Ages 65 to 75 Years	69.01% ★	58.89% ★	72.37% ★★★	R
Total	73.27% ★★★	70.11% ★★	72.16% ★★★	R
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage (Average MME ≥ 90)**	4.15% ★★★	3.84% ★★★	3.68% ★★★	R
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
Ages 3 Months to 17 Years	73.73% ★★★	77.02% ★★★	73.32% ★★★	R
Ages 18 to 64 Years	39.45% ★★	39.53% ★★	34.56% ★	R
Ages 65 Years and Older	26.32% ★	23.08% ★	30.77% ★★	R
Total	62.37% ★★★	64.78% ★★★	58.99% ★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Access/Availability of Care Domain				
Initiation and Engagement of SUD Treatment (IET)				
Initiation of SUD Treatment —Total—Ages 13 to 17 Years	34.09% ★	28.12% ★	32.94% ★	R
Engagement of SUD Treatment —Total—Ages 13 to 17 Years	12.50% ★★★	14.32% ★★★	12.83% ★★★	R
Initiation of SUD Treatment —Total—Ages 18 to 64 Years	36.68% ★	37.51% ★	38.41% ★	R
Engagement of SUD Treatment —Total—Ages 18 to 64 Years	11.14% ★★	11.52% ★★	10.70% ★★	R
Initiation of SUD Treatment —Total—Ages 65 Years and Older	44.27% ★★★	39.75% ★★	42.62% ★★	R
Engagement of SUD Treatment —Total—Ages 65 Years and Older	5.34% ★★	3.73% ★★	3.83% ★	R
Initiation of SUD Treatment —Total—Total	36.70% ★	36.65% ★	38.10% ★	R
Engagement of SUD Treatment —Total—Total	11.05% ★★	11.46% ★★	10.55% ★★	R
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	86.62% ★★★	86.37% ★★★	90.75% ★★★★	R
Postpartum Care	83.45% ★★★★	81.51% ★★★	88.81% ★★★★★	R
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Ages 1 to 11 Years	43.85% ★	46.74% ★★	52.99% ★★	R
Ages 12 to 17 Years	64.02% ★★★	53.72% ★★	60.70% ★★	R
Total	57.36% ★★	51.04% ★★	57.85% ★★	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	65.93% ★★★★	66.40% ★★★★	67.01% ★★★	R
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	66.66% ★★	69.43% ★★★	72.38% ★★★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	50.87% ★	51.48% ★	56.10% ★	R
Ages 12 to 17 Years	55.80% ★★★	56.41% ★★★	61.47% ★★★★	R
Ages 18 to 21 Years	24.15% ★★★	24.75% ★★	31.60% ★★	R
Total	48.24% ★★★	49.09% ★★	54.70% ★★	R
Utilization and Risk Adjusted Utilization Domain: Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Ages 18–64 Years	8.39% NC	9.23% NC	8.97% ★★★	R
Expected Readmissions—Ages 18–64 Years	10.92% NC	10.85% NC	9.19% NC	R
Observed/Expected Ratio—Ages 18–64 Years	0.7683 ★★★★★	0.8506 ★★★★	0.9755 ★★★★	R
Measures Reported Using ECDS				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	62.67% ★★★★★	62.28% ★★★★	63.15% ★★★★	R
Colorectal Cancer Screening (COL-E)				
Ages 46 to 50 Years	26.80% NC	35.95% NC	43.05% ★★★★★	R
Ages 51 to 75 Years	51.05% NC	53.38% NC	57.55% ★★★★★	R
Total	46.85% NC	49.59% NC	54.58% ★★★★★	R
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)				
Initiation Phase	47.98% NC	44.02% ★★	48.37% ★★★	R
Continuation and Maintenance Phase	55.04% NC	48.20% ★★	51.02% ★★	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)				
Blood Glucose Testing—Ages 1 to 11 Years	NA	41.65% ★★	41.08% ★★	R
Blood Glucose Testing—Ages 12 to 17 Years	NA	55.05% ★	54.44% ★	R

HEDIS Measures	MY 2022 HEDIS Rate	MY 2023 HEDIS Rate	MY 2024 HEDIS Rate	MY 2024 Audit Designation
Blood Glucose Testing—Total	NA	50.48% ★	49.50% ★	R
Cholesterol Testing—Ages 1 to 11 Years	NA	30.12% ★★	30.25% ★★	R
Cholesterol Testing—Ages 12 to 17 Years	NA	34.47% ★★	32.19% ★	R
Cholesterol Testing—Total	NA	32.99% ★★	31.47% ★	R
Blood Glucose and Cholesterol Testing—Ages 1–11 Years	NA	27.29% ★★	28.67% ★★	R
Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years	NA	32.16% ★★	31.13% ★	R
Blood Glucose and Cholesterol Testing—Total	NA	30.50% ★★	30.22% ★	R
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	0.00% ★★	18.88% ★★★★	42.48% ★★★★★	R
Follow-Up on Positive Screen	NA	NA	NA	R
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	0.04% ★★	6.05% ★★★	42.28% ★★★★★	R
Follow-Up on Positive Screen	NA	NA	NA	R

* 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 2024 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
HEDIS MY 2024 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 C-9—UHCCP's CMS Core Set Measure Rates

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 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)	46.94%	37.29%	39.17%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)			
*Ages 18 to 64**	4.44%	4.29%	4.20%

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate
*Age 65 and Older**	3.69%	4.98%	3.75%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)			
Ages 18 to 64	—	—	1.62%
Age 65 and Older	—	—	4.33%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)			
*Ages 18 to 64**	22.34%	23.55%	23.07%
*Age 65 and Older**	19.73%	19.33%	19.50%
Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	—	9.33%	8.57%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	—	44.13%	43.92%
LARC—Within 3 Days of Delivery	—	0.80%	0.67%
LARC—Within 90 Days of Delivery	—	16.93%	17.13%
Contraceptive Care—All Women Ages 21 to 44 (CCW-AD)			
Most or Moderately Effective Contraception	—	—	27.40%
LARC	—	—	6.34%
CMS Child Core Measures Set			
Developmental Screening in the First Three Years of Life (DEV-CH)			
Children Who Turned 1 Year	28.69%	25.46%	24.58%
Children Who Turned 2 Years	37.98%	31.04%	36.31%
Children Who Turned 3 Years	31.89%	28.06%	29.50%
Total	32.94%	28.21%	30.03%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)			
Ages 12 to 17	—	—	1.78%
Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)			
Most or Moderately Effective Contraception—Within 3 Days of Delivery	1.91%	0.60%	2.34%
Most or Moderately Effective Contraception—Within 90 Days of Delivery	50.24%	38.55%	45.03%
LARC—Within 3 Days of Delivery	0.96%	0.60%	0.58%
LARC—Within 90 Days of Delivery	23.92%	19.28%	18.13%

CMS Core Set Measures	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate
Contraceptive Care—All Women Ages 15 to 20 (CCW-CH)			
Most or Moderately Effective Method of Contraception	26.68%	24.99%	25.32%
LARC	4.29%	4.46%	4.22%
Oral Evaluation, Dental Services (OEV-CH)			
Age Less Than 3	—	—	27.41%
Ages 3 to 5	—	—	59.65%
Ages 6 to 14	—	—	62.19%
Ages 15 to 20	—	—	39.63%
Total	—	—	51.57%
Sealant Receipt on Permanent First Molars (SFM-CH)			
At Least One Sealant	—	—	3.85%
All Four Molars Sealed	—	—	2.04%
Prevention: Topical Fluoride for Children (TFL-CH)			
Dental or Oral Health Services—Ages 1 to 20	—	—	29.20%
Dental Services—Ages 1 to 20	—	—	27.91%
Oral Health Services—Ages 1 to 20	—	—	0.42%

* 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 or the rate was not displayed in the previous year(s).

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table C-10 for each activity. This table highlights the extent to which **UHCCP** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **UHCCP** can best address opportunities identified for each activity.

Table C-10—UHCCP Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
PMV		
+	**Strength:** The *Childhood Immunization Status (CIS)—Combination 3*, *Combination 7*, and *Combination 10* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for the *CIS—Combination 3*, *Combination 7*, and *Combination 10* indicators. **UHCCP**'s rates on the *CIS—Combination 3*, *Combination 7*, and *Combination 10* indicators demonstrate that children 2 years of age were receiving immunizations to help protect them against a potential life-threatening disease.	
+	**Strength:** The *Lead Screening in Children (LSC)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for the *LSC* measure. **UHCCP**'s rate on the *LSC* measure demonstrates that children under 2 years of age were adequately receiving a lead blood testing to ensure they were maintaining limited exposure to lead.	
+	**Strength:** The *Cervical Cancer Screening (CCS)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for the CS measure. **UHCCP**'s rate on the *CCS* measure demonstrates that enrolled members were receiving recommended preventive screenings.	
+	**Strength:** The *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid* and *Bronchodilator* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *PCE* indicators demonstrate that the MCO conducted timely follow-up with adult members who had an acute inpatient stay or ED visit due to COPD exacerbation to ensure the appropriate management of this chronic condition.	
+	**Strength:** The *Asthma Medication Ratio (AMR)—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** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *AMR* indicators demonstrate that the MCO effectively managed persistent asthma in enrolled members.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The *Controlling High Blood Pressure (CBP)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **UHCCP**'s rate on the *CBP* measure demonstrates that MCO was effective in helping members manage their blood pressure, reducing their risk for heart disease and stroke.	
+	**Strength:** The *Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status <8.0%* and *Glycemic Status >9.0%* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for these indicators. **UHCCP**'s rates on the *GSD—Glycemic Status <8.0%* and *Glycemic Status >9.0%* indicators demonstrate that the MCO was effective in helping adult members with diabetes adequately manage their blood sugar levels.	
+	**Strength:** The *Blood Pressure Control for Patients With Diabetes (BPD)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **UHCCP**'s rates on the *BPD* measure demonstrates that the MCO was effective in helping adult members with diabetes adequately manage their blood pressure.	
+	**Strength:** The *Eye Exam for Patients With Diabetes (EED)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **UHCCP**'s rate on the *EED* measure demonstrates that the MCO was effective in ensuring that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease.	
+	**Strength:** The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 75th percentile benchmark for this measure. **UHCCP**'s rate on the *SAA* measure demonstrates that the MCO's providers ensured that members with schizophrenia or schizoaffective disorder adhered to their treatment plan and continued to use prescribed antipsychotic medications.	
+	**Strength:** The *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **UHCCP**'s rates on the *AMM—Effective Acute Phase Treatment* and *Effective*	

Strength/ Opportunity for Improvement	Description	Domain(s)
	Continuation Phase Treatment indicators demonstrate that the MCO's 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).	
	Strength: The *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 6 to 17 Years*, *30-Day Follow-Up—Ages 6 to 17 Years*, *7-Day Follow-Up—Ages 18 to 64 Years*, *30-Day Follow-Up—Ages 18 to 64 Years*, *7-Day Follow-Up—Ages 65 Years and Older*, *30-Day Follow-Up—Ages 65 Years and Older*, *7-Day Follow-Up—Total*, and *30-Day Follow-Up—Total* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *FUH* indicators demonstrate that the MCO was effective in ensuring the members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of rehospitalization.	
	Strength: The *Follow-Up After ED Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *FUM—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* indicators demonstrate that the MCO properly managed care for patients discharged after an ED visit for mental illness, as they are vulnerable after release.	
	Strength: The *Follow-Up After ED Visit for Substance Use (FUA)—30-Day Follow-Up—Total* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *FUA—30-Day Follow-Up—Total* indicator demonstrates that the MCO properly managed care for patients discharged after an ED visit for substance use, as they are vulnerable after release.	
	Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. Members with serious mental illness who use antipsychotic medication are at increased risk for diabetes. **UHCCP**'s rate on the *SSD* measure demonstrates that	

Strength/ Opportunity for Improvement	Description	Domain(s)
	the MCO was 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.	
+	**Strength:** The *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years* and *Ages 65 Years and Older* measure indicators were a strength for **UHCCP** in MY2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *URI—Ages 18 to 64 Years* and *Ages 65 Years and Older* indicators demonstrate that the MCO effectively prevented or minimized the prescribing of antibiotics to treat adult members diagnosed with a URI.	
+	**Strength:** The *Use of Imaging Studies for Low Back Pain (LBP)—Ages 18 to 64 Years*, *Ages 65 to 75 Years*, and *Total* measure indicators were a strength for **UHCCP** in MY2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *LBP—Ages 18 to 64 Years*, *Ages 65 to 75 Years*, and *Total* indicators demonstrate that the MCO prevented or minimized the use of imaging to evaluate adult members with low back pain.	
+	**Strength:** The *Use of Opioids at High Dosage (HDO)* measure was a strength for **UHCCP** in MY2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **UHCCP**'s rate on the *HDO* measure demonstrates that the MCO effectively prevented or minimized the prescribing of opioids at a dosage of ≥90 mg morphine equivalent dose.	
+	**Strength:** The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years* measure indicator was a strength for **UHCCP** in MY2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *AAB—Ages 3 Months to 17 Years* indicator demonstrates that the MCO effectively prevented or minimized the prescribing of antibiotics to treat child members diagnosed with bronchitis or bronchiolitis.	
+	**Strength:** The *Initiation and Engagement of SUD Treatment (IET)—Engagement of SUD Treatment—Total —Ages 13 to 17 Years* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *IET—Engagement of SUD Treatment—Total —Ages 13 to 17 Years* indicator demonstrates that the MCO effectively engaged	

Strength/ Opportunity for Improvement	Description	Domain(s)
	young members with a new SUD episode in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment.	
+	**Strength:** The *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the PPC—*Timeliness of Prenatal Care* and *Postpartum Care* indicators demonstrate that the MCO effectively worked with providers to ensure 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.	
+	**Strength:** The *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* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *W30—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* indicators demonstrate that the MCO was effective in ensuring that children were seen by a PCP to assess and influence members' early development.	
+	**Strength:** The *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *WCV—Ages 12 to 17 Years* indicator demonstrates that the MCO was effective in ensuring that adolescents received appropriate well-care visits to provide screening and counseling.	
+	**Strength:** The *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Ages 18 to 64 Years* and *Observed/Expected Ratio—Total* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark on these indicators. **UHCCP**'s rates on these indicators demonstrate that MCO's providers had the appropriate processes in place to effectively coordinate care and provide support for members post-discharge.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The *Breast Cancer Screening (BCS-E)* measure was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this measure. **UHCCP**'s rate on the *BCS-E* measure demonstrates that the MCO was 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.	
+	**Strength:** The *Colorectal Cancer Screening (COL-E)—Ages 46 to 50 Years*, *Ages 51 to 75 Years*, and *Total* measure indicators were a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for these indicators. **UHCCP**'s rates on the *COL-E—Ages 46 to 50 Years*, *Ages 51 to 75 Years*, and *Total* indicators demonstrate that the MCO was effective in ensuring that adults 46 to 75 years of age have appropriate and timely screening for colorectal cancer.	
+	**Strength:** The *Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)—Initiation Phase* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on this indicator demonstrates that the MCO's providers ensured that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription.	
+	**Strength:** The *Prenatal Depression Screening and Follow-Up (PND-E)—Depression Screening* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *PND-E—Depression Screening* indicator demonstrates that the MCO's providers likely screened members for depression during prenatal care visits.	
+	**Strength:** The *Postpartum Depression Screening and Follow-Up (PDS-E)—Depression Screening* measure indicator was a strength for **UHCCP** in MY 2024. **UHCCP** ranked at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark for this indicator. **UHCCP**'s rate on the *PDS-E—Depression Screening* indicator demonstrates that the MCO's providers likely screened members for depression during postpartum care visits.	
−	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Weight Assessment and Counseling for Nutrition and Physical*	

Strength/ Opportunity for Improvement	Description	Domain(s)
	Activity for Children/Adolescents (WCC)—BMI Percentile—Total measure indicator. **Recommendations:** Monitoring the weight of children and adolescents can reduce the risk for obesity and prevent adverse health outcomes. HSAG recommends that **UHCCP** work with its providers to determine whether children and adolescent members receive a weight assessment and education on healthy habits during visits with PCP.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid 25th percentile benchmark for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, *Total* indicators. **Recommendations:** Screening adolescent and adult women can help identify chlamydia infections which, if untreated, can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1. HSAG recommends that **UHCCP** verify whether its providers 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.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)* measure. **Recommendations:** Monitoring blood glucose and cholesterol in persons with schizophrenia or schizoaffective disorder is necessary to prevent adverse metabolic events in this population. HSAG recommends that **UHCCP** work with its providers to ensure that members with schizophrenia and cardiovascular disease receive the appropriate cholesterol test to effectively monitor and manage their cardiovascular health.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *URI—Ages 3 Months to 17 Years* measure indicator. **Recommendations:** The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommends that **UHCCP** work with its providers to better understand the circumstances resulting in antibiotic prescribing for URI, and evaluate noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *AAB—Ages 18 to 64 Years* measure indicator. **Recommendations:** The inappropriate prescribing of antibiotics can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommends that **UHCCP** work with its providers to better understand the circumstances resulting in antibiotic prescribing for bronchitis/bronchiolitis, and evaluate noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years*, *Initiation of SUD Treatment—Total—Ages 18 to 64 Years*, and *Initiation of SUD Treatment—Total—Total* measure indicators. **Recommendations:** Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs. HSAG recommends that **UHCCP** work with its providers to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark on the *WCV—Ages 3 to 11 Years* measure indicator. **Recommendations:** Well-care visits provide an opportunity for providers to provide screening and counseling. HSAG recommends that **UHCCP** work with its providers to implement targeted interventions to ensure members receive timely and medically-appropriate well-care services.	
–	**Opportunity for Improvement: UHCCP** ranked below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)—Blood Glucose Testing—Ages 12 to 17 Years*, *Blood Glucose Testing—Total*, *Cholesterol Testing—Ages 12 to 17 Years*, *Cholesterol Testing—Total*, *Blood Glucose and Cholesterol Testing—Ages 12 to 17 Years*, *Blood Glucose and Cholesterol Testing—Total* measure indicators. **Recommendations:** Children and adolescents on antipsychotic medications are at increased risk for metabolic health complications. HSAG recommends that **UHCCP** work with its providers to establish new or bolster existing interventions to ensure that child and adolescent members prescribed antipsychotic medications	

Strength/ Opportunity for Improvement	Description	Domain(s)
	receive continuous blood glucose and cholesterol testing to enable metabolic monitoring and prevent advent health events.	

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 2024–2025 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 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.
Response
Describe initiatives implemented based on recommendations: *WCC-BMI Percentile Documentation - Total, Counseling for Nutrition-Total, and Counseling for Physical Activity-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: • Members with specific HEDIS gaps were identified for outreach and performance was monitored for these measures. Community Health Workers completed targeted outreaches for those identified with open gaps in Child and Adolescent Well-Care Visits (WCV) and Immunizations for Adolescents (IMA) which included education to authorized representatives regarding the body mass index (BMI) assessment, nutritional and physical activity counseling by providers at well-child visits. • The case management team addresses open opportunities in care including WCC and WCV during each successful telephonic interaction with a member or authorized representative. • Clinical Practice Consultants (CPCs) collaborate with practitioners and/or clinics providing updated member specific compliance data and education. Specific to the WCC measure, CPCs discussed the importance of documenting BMI, nutrition and physical activity counseling in the member's medical record in accordance with NCQA guidance. • The Quality Reference Guide is updated annually and posted to the provider website. It is an educational tool to describe quality measurement programs and tools used to address care opportunities.

- Practitioners were offered the opportunity to engage in Value Based Contracting to address opportunities in care for their members.
- Advocate4Me call center agents addressed member gaps in care when a member called Member Services.
- The Chief Medical Officer is engaged in ongoing education and discussion at Accountable Care Organization (ACO) Clinical Meetings and Joint Operating Committee (JOC) Meetings regarding approaches to improving WCC screening rates, as well as documentation regarding BMI, nutrition and physical activity counseling.
- On-demand training and monthly live provider education are offered via our provider website on several topics including HEDIS measure gap closure and EPSDT. The HEDIS training was presented on 2/26/2025 and EPSDT was presented on 8/27/2025.
- Various communication campaigns such as interactive voice recording reminders and educational mailers are utilized to prompt members to schedule appointments and close the identified gap in care.
- Member incentives are offered as gift cards to individuals who schedule and attend an appointment to complete their annual well-child visit. Eligibility for this program is based off the WCV measure to provide reminders of the need for annual preventive care appointments.
- Member education is provided via the 2025 UHCCP Heritage Health Member Handbook (pgs. 72-76) regarding the importance of an annual well-child visit, as well as language that specifically addresses that the exam should include weight (BMI) assessment (Member Handbook, pg. 76), counseling for nutrition, and counseling for physical activity.
- Member education is also provided on the Member Portal regarding weight and wellness.
- Data is used from our health information exchange to augment our existing gap identification processes.
- An initiative was implemented to modernize digital data collection, aligning with NCQA's strategic vision and advancing enterprise IT standards.

Chlamydia Screening in Women—Ages 16 to 20 Years, *Ages 21 to 24 Years*, and *Total*:

- UHCCP implemented multi-faceted activities and/or interventions to address recommendations for CHL screening. This includes but is not limited to the following:
- Members with the CHL HEDIS measure were identified for outreach. Community Health Workers outreached these members to provide education and assist in scheduling appointments to close this gap in care.
- Our maternity team works to close the chlamydia gap in care during prenatal outreaches to pregnant members.
- The case management team addresses open opportunities in care during each successful telephonic interaction with a member, including those identified as needing a chlamydia screening.
- CPCs collaborated with practitioners and/or clinics, providing updated member specific compliance data and education on chlamydia screenings.
- The Quality Reference Guide is updated annually and posted to the provider website. It is an educational tool to describe quality measurement programs and tools used to address care opportunities.
- Practitioners are offered the opportunity to engage in Value Based Contracting to address opportunities in care for their members.
- Advocate4Me call center agents address member gaps in care when a member called Member Services.
- The Chief Medical Officer is engaged in ongoing education and discussion at ACO Clinical Meetings and JOC Meetings regarding approaches to improve chlamydia screening rates.

- Clinical pathways projects with local community-based organizations that focused on STI treatment and education, mental health support and education, and SDOH resource connectivity were utilized.

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

WCC-BMI Percentile Documentation - Total, Counseling for Nutrition-Total, and Counseling for Physical Activity-Total; measure indicators showed an overall increase between 4.62-14.35 from MY2023 to MY2024 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile benchmark for these measure indicators.

Chlamydia Screening in Women—Ages 16 to 20 Years, *Ages 21 to 24 Years*, and *Total;* measure indicators showed an overall increase between 0.18-5.48 from MY2023 to MY2024 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile benchmark for these measure indicators. MY2024 was a baseline year for the Performance Improvement Project focused on chlamydia screenings.

Identify any barriers to implementing initiatives:

WCC-BMI Percentile Documentation - Total, Counseling for Nutrition-Total, and Counseling for Physical Activity-Total

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

- Incomplete claims submission which then requires a manual medical record review of provider documentation in order to close the gap in care.
- Provider's documentation of BMI, nutrition counseling, and physical activity counseling in the member's medical record in a manner that is not aligned with NCQA guidance on gap closure.
- Many provider EMR's require the BMI percentile to be entered manually, as their EMR is set up to enter the BMI as a number and not as a percentile.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*

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

- Lack of culturally competent provider availability; lack of access to in-network providers in rural and frontier counties; difficulty in billing and coding submissions affects submission of data; member fear of lack of confidentiality in EOBs or billing; and individuals obtaining screening and treatment from providers (i.e., free clinics) that do not rely on UHCCP for payment of services, as this causes UHCCP to be unable to confirm if testing took place via claims submission.
- Lack of awareness of chlamydia and symptoms; insufficient or lack of consistent communication means; health literacy, cultural, and/or linguistic barriers; lack of understanding of covered benefits; insufficient and/or lack of convenient transportation; concerns about confidentiality, especially for minors as the guardian may not know the member is sexually active; embarrassment related to discussing sexual health/lack of trust with provider; and members who see OB/GYN for reproductive health care, not their PCP, but do not engage with this provider within a certain period of time.
- Difficulty in billing and coding affects submission of data; lack of knowledge about current chlamydia screening guidelines; not routinely offering chlamydia screening to all eligible patients or the perception that the patient is not high risk; lack of culturally competent education materials; and limited after-hours access.

Identify strategies for continued improvement or overcoming identified barriers:

WCC-BMI Percentile Documentation - Total, Counseling for Nutrition-Total, and Counseling for Physical Activity-Total:

- UHCCP's strategy to address identified barriers includes the continued utilization of the implemented activities and/or interventions as described in this response. UHCCP also plans to complete the following:
- Enhance data sharing capabilities with providers, electronic medical records, and local health departments.
- Include education articles in the member newsletters covering topics on the importance of the annual child and adolescent well-child visit.
- Complete provider education on the documentation and billing codes for WCC measures.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*

- UHCCP's strategy to address identified barriers includes the continued utilization of the implemented activities and/or interventions as described in this response. UHCCP is also completing the following:
- Implementation of a Performance Improvement Project (PIP) titled Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16-24 Years which is in currently in Remeasurement Year 1 with interventions having started January 1, 2025.
- Continuing to offer practitioners the opportunity to engage in Value Based Contracting to address opportunities in care for their members.

HSAG Assessment: **UHCCP** implemented interventions to improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* measure indicators, including member outreach and provider education. **UHCCP**'s rates on the *WCC—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* indicators improved from MY 2023 to MY 2024; however, the rate on the *BMI Percentile Documentation* indicator remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on these indicators.

UHCCP implemented interventions to improve performance on the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators, including member outreach, provider education, and a performance improvement project. **UHCCP**'s rates on the *CHL—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* indicators improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on these indicators.

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

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.

Response

Describe initiatives implemented based on recommendations:

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older:

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:

- Targeted communications were sent to behavioral health providers and facilities to promote follow-up care, virtual visit options, and updates to technical specifications for relevant HEDIS measures.
- Educational materials such as banners, billing code references, and downloadable guides were made available to providers.
- Training was delivered to various provider groups and support staff through webinars and video series, some offering continuing education credits.
- Lists of accessible providers, including virtual care options, were distributed to facilitate timely access to services.
- Educational content on screening, brief intervention, and treatment referral was developed and shared via provider portals.
- Resources were updated and distributed to support evidence-based treatment approaches.
- A structured outreach plan was executed to inform stakeholders of changes to HEDIS specifications:
  - Included newsletters, emails, online postings, and live presentations.
  - Communications targeted outpatient and inpatient behavioral health providers.
  - Training was provided to internal teams to ensure alignment and understanding of updated specifications.

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:

- UHCCP has increased medication reviews for all members in the NE Wards rate group, regardless of age, who are prescribed more than three psychotropic medications are referred to the health plan's pharmacist for review. Those members under six years old who are prescribed psychotropic medication are referred to the health plan's pharmacist for review. The pharmacist provides feedback on any medication interaction or dosing concerns.
- Through coordination with state partners, member specific psychotropic medication use is discussed and reviewed during DHHS staffing on a regular basis. This information is then utilized by the members' external care team to ensure the members' health conditions are monitored and addressed.
- Education is regularly provided to non-clinical external partners about the APM measure and why it is important.
- UHCCP has several Drug Utilization Review processes to flag members with antipsychotic use to ensure appropriate prescribing. Reviews include members' age, doses, potential interactions, and diagnosis. This ensures members receive evidenced based use of antipsychotics and prevents overuse of these products in

the child and adolescent populations.

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

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older measure indicator increased by 36.67 from MY2023 to MY2024 and is in NCQA's Quality Compass national Medicaid HMO HEDIS MY 2024 90th percentile benchmark for this measure indicator.

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 showed an overall decrease between 0.61-1.03 from MY2023 to MY2024 and remained lower than NCQA's Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile benchmark for these measure indicators.

Identify any barriers to implementing initiatives:

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older

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

- Provider network understanding of HEDIS requirements and incomplete discharge documentation.
- Reluctance among primary care providers to treat behavioral health conditions.

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*

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

- Gaps in care coordination following the initiation of antipsychotic medications.
- Missed opportunities for annual well-child visits, which are essential for ensuring completion of preventive and recommended screenings.

Identify strategy for continued improvement or overcoming identified barriers:

The health plan remains committed to advancing quality improvement through the provider and member-focused interventions as described above. The health plan will review its current strategies and root cause analysis processes to ensure they are effective, making updates as needed. In addition to the initiatives previously outlined, the following strategies will also be implemented:

F*ollow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 Years and Older* – strategies for continued improvement or reduce barriers to HEDIS gap closure includes but is not limited to:

- Targeted and ongoing education is being provided to clinical and administrative staff to ensure consistent awareness and application of updated HEDIS specifications.
- The development of a state-specific training module focused on screening, brief intervention, and referral to treatment to decrease the reluctance among primary care providers to treat behavioral health.

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* strategies to improve gap closure:

- Collaborate with UHCCP pharmacist to identify children prescribed antipsychotic medications.
- Increase education to PCP offices on HEDIS specifications around metabolic monitoring and antipsychotic prescriptions.
- Complete an analysis of prescribing providers to members who are identified as non-compliant for this measure to locate trends and complete targeted education.

HSAG Assessment: **UHCCP** implemented interventions to improve performance on the *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 65 Years and Older* measure indicator, focusing on provider outreach and education. **UHCCP**'s rate on the *FUH—7-Day Follow-Up—Ages 65 Years and Older* indicator improved substantially between MY 2023 and MY 2024, and exceeded the QC national Medicaid HEDIS MY 2024 50th percentile benchmark.

UHCCP implemented interventions to improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)—Blood Glucose—12 to 17 Years* and *Total,* and *Blood Glucose and Cholesterol—12 to 17 Years* measure indicators, including efforts to review the prescribing of psychotropic medications and promote data sharing with care managers to facilitate monitoring of relevant members' health condition. **UHCCP**'s rates on the *APM-E—Blood Glucose—12 to 17 Years* and *Total,* and *Blood Glucose and Cholesterol—12 to 17 Years* indicators declined slightly between MY 2023 and MY 2024 and were below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on these indicators.

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

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.

Response

Describe initiatives implemented based on recommendations:

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* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*

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:

- Annual distribution of UHC PATH Guides via our online provider website.
- Provider antibiotic usage is made available in Provider Profiles that are run by UHCCP in April and October of each year.
- Member newsletters detailing asthma and COPD management programs.

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

Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years and *Ages 65 Years and Older;* ages 3 mo-17 yrs measure indicator decreased by 0.25 from MY2023 to MY2024 and remained below

NCQA's Quality compass national Medicaid HMO HEDIS MY2024 25th percentile benchmark for this indicator, while ages 65 yrs and older showed a 14.85 increase from MY2023 to MY2024 and is in the NCQA's Quality compass national Medicaid HMO HEDIS MY2024 50th percentile benchmark for this indicator.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older; this measure indicator improved by 7.69 from MY2023 to MY2024 and remained below the NCQA's Quality compass national Medicaid HMO HEDIS MY2024 25th percentile benchmark for this indicator.

Identify any barriers to implementing initiatives:

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

- Insufficient member knowledge on the importance of proper use of antibiotics and requesting pharmaceutical remedies prior to or without testing.
- Providing pharmaceutical treatment to individuals who are showing signs of illness prior to or without 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 interventions as described in this response. We also plan to do the following:

- Complete a trend analysis of providers with high antibiotic utilization.
- Increase education to providers via HEDIS provider webinars.
- Explore working with University of Nebraska Medical Center (UNMC) Antimicrobial Stewardship Assessment and Promotion Program (ASAP) again. UHCCP had worked with this program in 2023 and they partnered with UHCCP in providing education to our Providers.

HSAG Assessment: **UHCCP** implemented interventions to improve performance on the *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years* and *Ages 65 Years and Older* measure indicators, including provider education and the exploration of a partnership to focus on antibiotic stewardship. **UHCCP**'s rate on the *URI—Ages 3 Months to 17 Years* indicator declined slightly between MY 2023 and MY 2024, and remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. However, **UHCCP**'s rate on the *URI—65 Years and Older* indicator improved substantially between MY 2023 and MY 2024, and was at or above the QC national Medicaid HEDIS MY 2024 50th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on this measure for child and adolescent members.

UHCCP implemented interventions to improve performance on the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 65 Years and Older* measure indicator, including provider education and the exploration of a partnership to focus on antibiotic stewardship. **UHCCP**'s rate on the *AAB—Ages 65 Years and Older* indicator improved between MY 2023 and MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 50th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on this indicator.

***Recommendation (*Effectiveness of Care: 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.
Response

Describe initiatives implemented based on recommendations:
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:
• Targeted communications were sent to behavioral health providers and facilities to promote follow-up care, virtual visit options, and updates to technical specifications for relevant HEDIS measures.
• Educational materials such as banners, billing code references, and downloadable guides were made available to providers.
• Training was delivered to various provider groups and support staff through webinars and video series, some offering continuing education credits.
• Updated tools were provided to support screening and treatment for substance use disorders.
• Lists of accessible providers, including virtual care options, were distributed to facilitate timely access to services.
• Educational content on screening, brief intervention, and treatment referral was developed and shared via provider portals.
• Resources were updated and distributed to support evidence-based treatment approaches.
• A structured outreach plan was executed to inform stakeholders of changes to HEDIS specifications:
  − Included newsletters, emails, online postings, and live presentations.
  − Communications targeted outpatient and inpatient behavioral health providers.
  − Training was provided to internal teams to ensure alignment and understanding of updated specifications.
• UHCCP pharmacist identified members with prescriptions for Medication Assisted Treatment (MAT). Care Managers completed outreaches to the identified members to confirm they have a follow-up appointment to address the medication and how it is working.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): *Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total;* measure indicators showed an overall increase between 0.90-4.82 from MY2023 to MY2024 and remained lower than NCQA's Quality Compass national Medicaid HMO HEDIS MY 2023 25th percentile benchmark for these measure indicators.
Identify any barriers to implementing initiatives: Identified barriers to HEDIS gap closure includes but is not limited to: • Provider network understanding of HEDIS requirements and incomplete discharge documentation. • Reluctance among primary care providers to treat behavioral health conditions and substance use disorders. • Lack of member compliance to medications and follow up appointments related to member readiness for change.

- In review of some specific cases it appeared SUD diagnoses, for example marijuana use and a binge drinking episode causing intoxication, were not prioritized for treatment, leading to follow-up visits where the diagnosis wasn't addressed or the care gap closed. This raises concerns that aggressive coding strategies may include individuals in measures who aren't clinically relevant.

Identify strategies for continued improvement or overcoming identified barriers:

The health plan remains committed to advancing quality improvement through the provider and member-focused interventions as described above. The health plan will review its current strategies and root cause analysis processes to ensure they are effective, making updates as needed. In addition to the initiatives previously outlined, the following strategies will also be implemented:

Strategies for continued improvement or to reduce barriers to HEDIS gap closure includes but is not limited to:

- Targeted and ongoing education is being provided to clinical and administrative staff to ensure consistent awareness and application of updated HEDIS specifications.
- The development of a state-specific training module focused on screening, brief intervention, and referral to treatment to decrease the reluctance among primary care providers to treat behavioral health and substance use disorders.

HSAG Assessment: **UHCCP** implemented interventions to improve performance on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators, including provider outreach and education. **UHCCP**'s rates on the *IET—Initiation of SUD Treatment—Total—Ages 13 to 17 Years, Ages 18 to 64 Years,* and *Total* indicators improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on these indicators.

***Recommendation (*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.

Response

Describe initiatives implemented based on recommendations:

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:

- Members with WCV specific HEDIS gaps were identified for outreach and performance was monitored for these measures.
- The case management team addresses open opportunities in care during each successful telephonic interaction with a member, including WCV.
- CPCs collaborated with practitioners and/or clinics, providing updated member specific compliance data and education.
- The Quality Reference Guide is updated annually and posted to the provider website. It is an educational

tool to describe quality measurement programs and tools used to address care opportunities.

- Practitioners are offered the opportunity to engage in Value Based Contracting to address opportunities in care for their members.
- Quality member initiatives that specifically address open gaps in care are made through member outreach.
- Advocate4Me call center agents address member gaps in care when a member calls in to Member Services.
- The Chief Medical Officer is engaged in ongoing education and discussion at ACO Clinical Meetings and JOC Meetings regarding approaches to improve WCV screening rates.
- On-demand training and monthly live provider education are offered via our provider website on several topics including HEDIS measure gap closure and EPSDT.
- Various communication campaigns such as interactive voice recording reminders and education mailers are utilized to prompt members to schedule appointments and close the identified gap in care.
- Member incentives are offered as gift cards to individuals who schedule and attend an appointment to complete their annual well-child visit. This program is based off the WCV measure to ensure all children and adolescents are reminded of the need for annual preventive care appointments.
- Member education is provided via the 2025 UHCCP Heritage Health Member Handbook (pgs. 72-76) regarding the importance of an annual well-child visit.
- Using data from our health information exchange to augment our existing gap identification processes.
- UHCCP conducts ongoing data analysis and stratification of the HEDIS WCV measure across key demographics, including race, ethnicity, language, and ZIP code. Although no targeted interventions were implemented for the 3–11-year sub-measure as recommended, the health plan did initiate efforts to address racial/ethnic disparities identified in the 12–17-year sub-measure. These initiatives aim to uncover best practices for ensuring children receive timely and medically appropriate well-care services.

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

Child and Adolescent Well-Care Visits—Ages 3 to 11 Years; measure indicator increased by 1.62 from MY2023 to MY2024 and remained below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2024 25th percentile benchmark for these measure indicators.

Identify any barriers to implementing initiatives:

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

- Members' authorized representatives' motivation to receive and knowledge of recommended preventative and follow-up services.
- Members' authorized representatives' vaccine misinformation and fatigue.
- A key barrier to well-child visits is that providers are prioritizing flexibility over strict timing for appointments, which creates challenges for meeting time-sensitive metrics—especially for older age groups.
- Coding issues have emerged when providers address preventive care during acute visits but fail to code it in a way that closes the care gap.

Identify strategy for continued improvement or overcoming identified barriers:

UHCCP's strategy to address identified barriers includes the continued utilization of the implemented activities and/or interventions as described in this response. We will also complete the following:

- Additionally, UHCCP will include education articles in the quarterly member newsletters covering topics on the importance of the annual child and adolescent well-child visit.
- UHCCP will also collaborate with ACOs to ensure state focus measures are prioritized and addressed, as well as develop improved collaboration with Public Health Departments with possible data sharing to help

with identifying unaddressed gaps in care.
HSAG Assessment: **UHCCP** implemented interventions to improve performance on the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* measure indicator, including member and provider outreach, engagement, and education. **UHCCP**'s rate on the *WCV—Ages 3 to 11 Years* indicator improved from MY 2023 to MY 2024, but remained below the QC national Medicaid HEDIS MY 2024 25th percentile benchmark. HSAG recommends that **UHCCP** continue efforts to improve performance on this indicator.

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)**	Year Four (CY 2025–2026)**
Standard Number and Title	**UHCCP Results**			
Standard I—Enrollment and Disenrollment	100%			50%
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%		94%
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%			100%
Standard IX—Subcontractual Relationships and Delegation	75%			100%
Standard X—Practice Guidelines	100%		100%	
Standard XI—Health Information Systems	100%			100%
Standard XII—Quality Assessment and Performance Improvement	100%			100%
Standard XIII—Grievance and Appeal System		100%	100%	

* Bold text indicates standards that HSAG reviewed during CY 2025–2026.

** Grey shading indicates standards for which no comparison results are available.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table C-13 for each activity. This table highlights the extent to which **UHCCP** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **UHCCP** can best address opportunities identified for each activity.

Table C-13—UHCCP Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
Assessment of Compliance With Medicaid Managed Care Regulations		
+	**Strength: 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.	
+	**Strength:** Four out of six standards met 100 percent compliance and identified no required actions.	
+	**Strength: UHCCP** achieved full compliance with the Provider Selection and Program Integrity standard, demonstrating **UHCCP** had appropriate provider monitoring and processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. **UHCCP** had developed a compliance committee to ensure information sharing at the staff, management, and leadership level.	
+	**Strength: UHCCP** achieved full compliance with the Subcontractual Relationships and Delegation standard, demonstrating **UHCCP** had proper oversight and management with contracted vendors.	
+	**Strength: UHCCP** achieved full compliance with Health Information Systems standard, demonstrating effective data collection, validation, reporting, encounter submission, and interoperability aligned with federal and State requirements.	
+	**Strength: UHCCP** achieved full compliance with the QAPI standard, demonstrating a robust QAPI program with effective governance, performance measurement, and under- and overutilization monitoring; MLTC-approved PIPs; and timely reporting to MLTC.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: UHCCP** did not include all elements of the requirement in a policy or procedure. **UHCCP** did not include sub elements 4d, 4e, and 4f in its policy per federal requirement 42 CFR §438.56(b)(2) and MLTC contract requirement V(B)(8)(a): The MCO does not request disenrollment because of: • The member's diminished mental capacity; • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members); • *The member attempts to exercise their rights under the MCO's grievance system, or attempts to exercise their right to change, for cause, the PCP that they chose or was assigned.* **Recommendations: UHCCP** must include all elements of the requirement in a policy or procedure. **UHCCP** must update its policy to include all elements of federal requirement 42 CFR §438.56(b)(2) and MLTC contract requirement V(B)(8)(a): The MCO does not request disenrollment because of: • The member's diminished mental capacity; • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members); • *The member attempts to exercise their rights under the MCO's grievance system, or attempts to exercise their right to change, for cause, the PCP that they chose or was assigned.*	
–	**Opportunity for Improvement: UHCCP** did not include federal requirement 42 CFR §438.56(b)(3) in a policy or procedure. **Recommendations: UHCCP** must include federal requirement 42 CFR §438.56(b)(3) in a policy or procedure. **UHCCP** must update its policy to include: "The MCO assures MLTC that it does not request disenrollment for reasons other than those permitted under the contract."	
–	**Opportunity for Improvement: UHCCP** did not include all elements of the federal requirement 42 CFR §438.56(c)(2) in a policy or procedure. **Recommendations: UHCCP** must include all elements of the federal requirement 42 CFR §438.56(c)(2) in a policy or procedure. **UHCCP** must update its policy to include elements outlined in requirement 42 CFR §438.56(c)(2)(iii) and (iv): The member may request disenrollment from the MCO as follows:	

Strength/ Opportunity for Improvement	Description	Domain(s)
	• Without cause, at the following times: – Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. – When MLTC imposes the intermediate sanction specified in 42 CFR §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or MLTC notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.	
–	**Opportunity for Improvement: UHCCP** did not include all elements of the federal requirement 42 CFR §438.56(d)(2) and MLTC Contract V(B)(7)(c) in a policy or procedure. **Recommendations: UHCCP** must include all elements of the federal requirement 42 CFR §438.56(d)(2) and MLTC Contract V(B)(7)(c) in a policy or procedure. **UHCCP** must update its policy to include: The member may request disenrollment from the MCO for cause, at any time, under any one of the following circumstances: • The member moves out of the MCO's service area *(out of state)*. • The MCO does not, because of moral or religious objections, cover the service the member seeks. • The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk. • For other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.	
–	**Opportunity for Improvement: UHCCP** did not include all elements of federal requirement 42 CFR §438.56(d) and MLTC Contract V(B)(7)(e) in a policy and procedure. **Recommendations: UHCCP** must include all elements of federal requirement 42 CFR §438.56(d) and MLTC Contract V(B)(7)(e) in a policy and procedure. "The MCO must update its policy to include: The member *(or their representative)* must request disenrollment by submitting an oral or written request with cause to the enrollment broker for action by MLTC."	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement: UHCCP**'s policies and procedures stated the monitoring of a network of appropriate providers to provide adequate access to all services covered under the contract for all members, which included those with limited English proficiency or physical disabilities. However, the policy did not address members with mental disabilities. During the interview session, **UHCCP**'s staff members were unable to describe how the MCO monitors the provider network to provide access for members with mental disabilities. The follow-up narrative submitted by **UHCCP** did not provide evidence of how the MCO monitors the provider network to ensure access for members with mental disabilities. **Recommendations: UHCCP** must revise its policies and procedures and ensure that the MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with mental disabilities.	

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

Table C-14 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 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-14—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 2024 Compliance Review Report on November 27, 2024. Responses to all Required Corrective Actions were due January 27, 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 Contract Year 2024 Compliance Review Report being submitted by the due date of January 27, 2024.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategies 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 2024–2025 recommendation.

Recommendation
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.*
Response
Describe initiatives implemented based on recommendations: Regarding the specialist letter, this recommendation was captured and is being considered as part of an initiative to revise all member notifications of provider terminations. Regarding the finding related to paper copies, the required documents and the website were updated to reflect the HSAG-suggested verbiage. This was confirmed in UHCCPs 2024 Compliance Review CAP response approved by HSAG on 4/23/2025. UHCCP further confirmed in its CAP response that a new SOP was developed for Member Services staff and a notice went out to Member Services staff notifying them of the new SOP.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.

Identify any barriers to implementing initiatives: Educating the organization on the requirement to provide paper copies of all documents provided in electronic format in 5 business days and implementing this process for the health plan.
Identify strategies for continued improvement or overcoming identified barriers: We do not anticipate any barriers going forward.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
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 notice of adverse benefit determination (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.
Response
Describe initiatives implemented based on recommendations: Regarding the Recommendation related to the OptumRx Delegated UnitedHealthcare Prior Authorization Policy and Procedure. The addition of the suggested language was added to the Policy and Procedure following the virtual onsite and sent as part of the follow up items from the Virtual Review to HSAG on July 18, 2024. Regarding the Required action related to NABD notices. There was one file during the case file review that was not in compliance as the NABD was sent on the 15th calendar day rather than the 14th calendar day. A corrective action plan related to this finding was approved by HSAG on April 4, 2025.
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: Regarding the recommendation related to the OptumRx Delegated UnitedHealthcare Prior Authorization Policy and Procedure: OptumRx was already adhering to the required timeframe and as evidenced in the file review portion of the audit. This was an update to the Policy and Procedure only as it was already implemented as part of the process. Regarding the finding related to NABD notification: Managers and supervisors continue daily monitoring of work queues for request prioritization and inventory reports.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2024–2025 recommendation.

Recommendation
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.
Response
Describe initiatives implemented based on recommendations: The Clinical Practice Guidelines were added to the public facing website on July 12, 2025.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: When updates are made to the Clinical Practice Guidelines the new version is posted on the public facing website. There are no barriers to overcome at this time.
HSAG Assessment: **UHCCP** sufficiently addressed the CY 2024–2025 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 time frame and within the scope of the NAV audit. 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-15 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-15—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, optometrists, and ophthalmologists, for which the standard is defined in terms of a maximum travel time from the member's residence.

Table C-16 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-16–Percentage of UHCCP Members With Required Access to Care by Provider Category

Provider Category	Percent of Members With Required Access*
PCP, Urban	100.0%
PCP, Rural	100.0%
PCP, Frontier	100.0%
High-Volume Specialists**	
Cardiology	>99.9%^
Neurology	>99.9%^
OB/GYN	100.0%
Oncology-Hematology	99.8%^
Orthopedics	100.0%
Pharmacy, Urban	96.3%

Provider Category	Percent of Members With Required Access*
Pharmacy, Rural	93.4%
Pharmacy, Frontier	97.8%
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	>99.9%^
All Behavioral Health Outpatient Assessment and Treatment Providers, Frontier	98.3%^
Hospitals	99.2%^
Optometry, Urban	>99.9%^
Optometry, Rural	>99.9%^
Optometry, Frontier	100.0%
Ophthalmology, Urban	98.1%^
Ophthalmology, Rural	100.0%
Ophthalmology, Frontier	91.3%^
Dental	
Dentist, Urban	100.0%
Dentist, Rural	99.9%^
Dentist, Frontier	100.0%
Dental Specialists	
Oral Surgeon, Urban	88.6%
Oral Surgeon, Rural	65.2%^
Oral Surgeon, Frontier	22.4%^
Orthodontist, Urban	83.0%^
Orthodontist, Rural	58.7%^
Orthodontist, Frontier	78.4%
Periodontist, Urban	76.8%^
Periodontist, Rural	37.5%^
Periodontist, Frontier	0.0%^
Endodontist, Urban	76.8%^
Endodontist, Rural	37.9%^
Endodontist, Frontier	0.0%^
Prosthodontist, Urban	76.8%^
Prosthodontist, Rural	37.6%^
Prosthodontist, Frontier	0.0%^
Pediadontist, Urban	97.5%
Pediadontist, Rural	84.4%

Provider Category	Percent of Members With Required Access*
Pediadontist, Frontier	86.8%

Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider type, in a specific urbanicity. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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 geographic network distribution analysis.
***DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties. Urban results are included for informational purposes.

Table C-17 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-17–Percentage of UHCCP Members With Required Access to Behavioral Health Services by Type of Service and Behavioral Health Region

Provider Category	Percent 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	98.8%^
Region 3	99.9%^
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. Values in cells where the MCO did not meet the minimum geographic access standard are denoted with a caret (^).
*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-18 identifies the counties where HSAG identified that **UHCCP** did not meet the minimum geographic access standards in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table C-18–Counties Not Meeting Geographic Access Standard by Provider Category for UHCCP

Provider Category	Counties Not Meeting Standard*
High-Volume Specialists†**	
Cardiology	Cherry
Neurology	Dundy, Sheridan
Oncology-Hematology	Boyd, Cherry, Grant, Holt, Keya Paha, Rock
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Clay, Custer
Frontier	Grant, Hooker, Thomas
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Blaine, Grant, Hooker, Thomas
Region 2	Grant, Hooker, Lincoln, Thomas
Region 3	Blaine
Region 4	Cherry
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Boyd, Brown, Buffalo, Cedar, Cherry, Custer, Dawes, Dixon, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Knox, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Optometry	
Urban	Buffalo, Lincoln
Rural	Cherry
Ophthalmology	
Urban	Adams, Buffalo, Dawson, Lincoln
Frontier	Sheridan
Dental	
Dentist, Rural	Cherry
Dental Specialists	
Oral Surgeon, Urban	Dawson, Gage, Lincoln, Madison, Platte, Scotts Bluff
Oral Surgeon, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Nance, Pawnee, Pierce, 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

Provider Category	Counties Not Meeting Standard*
Orthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Hall, Madison, Platte
Orthodontist, Rural	Antelope, Boone, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Dixon, Hamilton, Harlan, Holt, Howard, Kearney, Knox, Merrick, Nance, Nuckolls, Phelps, Pierce, Richardson, Stanton, Thayer, Valley, Wayne, Webster
Orthodontist, Frontier	Boyd, Brown, Greeley, Keya Paha, Rock, Sheridan, Wheeler
Periodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Periodontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, 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
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
Endodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Endodontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, 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
Endodontist, 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
Prosthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Prosthodontist, Rural	Antelope, Boone, Box Butte, Cedar, Cherry, Cheyenne, Clay, Cuming, Custer, Dawes, Dixon, 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
Prosthodontist, 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
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dawes, Furnas, Holt, Knox, Red Willow, Richardson, Valley

Provider Category	Counties Not Meeting Standard*
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 geographic network distribution analysis.

Approved County Exceptions

As part of network monitoring and reporting, each MCO had the opportunity to identify provider categories for which it failed to meet specified minimum geographic access standards. All three MCOs completed and submitted Network Adequacy Exceptions reports to DHHS for review and approval, including reasons for each exception requested. As part of the NAV data collection process, DHHS provided HSAG with the approved MCO exceptions applicable to this measurement period.

As part of NAV, HSAG reviewed the approved exceptions for each MCO and compared against provider categories for which the MCO did not meet the established network standard.

Table C-19 displays the counties for which **UHCCP** received approval for exception by applicable geographic access standard and provider category.

Table C-19—Approved County Exceptions for UHCCP

Provider Category	Counties With Approved Exception*
PCP	
Urban	Lincoln
Rural	Cherry
High-Volume Specialists†**	
Neurology	Brown, Cherry, Keya Paha, Rock, Sheridan
OB/GYN	Cherry
Oncology-Hematology	Cherry
Pharmacy	
Urban	Buffalo, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Boone, Burt, Clay, Custer, Nance
Frontier	Hooker, Thomas
All Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Hooker, Thomas

Provider Category	Counties With Approved Exception*
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Boyd, Brown, Buffalo, Cherry, Custer, Dawes, Dawson, Frontier, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Optometry	
Urban	Adams, Buffalo, Lincoln
Rural	Cherry
Ophthalmology	
Urban	Buffalo, Lincoln, Madison, Platte
Dental	
Dentist, Rural	Cherry
Dental Specialists	
Oral Surgeon, Urban	Buffalo, Dakota, Dawson, Gage, Lincoln, Madison, Platte, Scotts Bluff
Oral Surgeon, Rural	Antelope, Box Butte, Cedar, Cherry, Cheyenne, Custer, Dawes, Dixon, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Merrick, Nance, Nemaha, Pawnee, Phelps, Pierce, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne
Oral Surgeon, Frontier	Arthur, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas, Wheeler
Orthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Gage, Hall, Madison, Platte
Orthodontist, Rural	Antelope, Boone, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Dixon, Fillmore, Hamilton, Harlan, Holt, Howard, Jefferson, Kearney, Knox, Merrick, Nance, Nuckolls, Pawnee, Phelps, Pierce, Polk, Richardson, Stanton, Thayer, Valley, Wayne, Webster, York
Orthodontist, Frontier	Boyd, Brown, Franklin, Garfield, Greeley, Keya Paha, Rock, Sheridan, Sherman, 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	All Frontier Counties

Provider Category	Counties With Approved Exception*
Endodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Endodontist, 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, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Endodontist, Frontier	All Frontier Counties
Prosthodontist, Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Prosthodontist, 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
Prosthodontist, Frontier	All Frontier Counties
Pediadontist, Urban	Dakota, Dawson, Gage, Platte
Pediadontist, Rural	Cherry, Cheyenne, Custer, Dixon, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Pawnee, Red Willow, Richardson, Valley
Pediadontist, Frontier	Boyd, Brown, Dundy, Keya Paha, Rock

*Results are shown only for those provider types for which at least one county had an exception request approved. Note that "all counties" refers to all counties designated by Nebraska as a specific urbanicity. There are 14 urban counties, 48 rural counties, or 31 frontier counties.
**The standard for this provider category does not differ by urbanicity.
†High-
Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.

Network Capacity Analysis

Table C-20 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-20—UHCCP Provider-to-Member Ratios by Provider Category

Provider Category	Providers	Ratio*
PCP	4,432	1:26

Provider Category	Providers	Ratio*
High-Volume Specialists**		
Cardiology	347	1:330
Neurology	298	1:385
OB/GYN	419	1:96
Oncology-Hematology	186	1:616
Orthopedics	532	1:216
Pharmacy	506	1:227
All Behavioral Health Inpatient and Residential Service Providers	34	1:3,368
All Behavioral Health Outpatient Assessment and Treatment Providers	2,866	1:40
Hospitals	114	1:1,005
Optometry	410	1:280
Ophthalmology	124	1:924
Dental		
Dentist	486	1:236
Dental Specialists		
Oral Surgeon	28	1:4,089
Orthodontist	22	1:5,204
Periodontist	11	1:10,408
Endodontist	7	1:16,355
Prosthodontist	8	1:14,311
Pediadontist	66	1:903

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 cases of OB/GYNs (where the member population was limited to females aged 15 years of age and older), and Pediadontists (where the member population was limited to members aged 18 and under).
** High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution 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-21 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-21–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	2.0 / 1.7	2.1 / 1.8

Provider Category	First Nearest* Time (Min.) Dist. (Mi.)	Second Nearest* Time (Min.) Dist. (Mi.)
High-Volume Specialists**		
Cardiology	8.8 / 7.5	10.0 / 8.5
Neurology	11.2 / 9.7	13.8 / 11.8
OB/GYN	7.8 / 6.8	10.1 / 8.7
Oncology-Hematology	9.0 / 7.5	11.8 / 10.1
Orthopedics	6.2 / 5.2	7.7 / 6.4
Pharmacy	2.6 / 2.2	4.7 / 4.0
All Behavioral Health Inpatient and Residential Service Providers	14.3 / 12.4	26.4 / 22.9
All Behavioral Health Outpatient Assessment and Treatment Providers	2.9 / 2.5	3.3 / 2.8
Hospitals	6.0 / 4.9	13.8 / 11.6
Optometry	4.1 / 3.5	4.5 / 3.8
Ophthalmology	9.0 / 7.6	11.0 / 9.4
Dental		
Dentist	5.0 / 4.3	7.5 / 6.4
Dental Specialists		
Oral Surgeon	37.9 / 33.3	60.4 / 50.8
Orthodontist	29.8 / 25.2	35.9 / 28.4
Periodontist	81.9 / 57.1	81.9 / 57.1
Endodontist	80.7 / 56.4	81.8 / 57.1
Prosthodontist	81.1 / 56.7	81.9 / 57.1
Pediadontist	15.6 / 13.5	19.3 / 16.6

*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 geographic network distribution analysis.

Table C-22 provides a comparison of **UHCCP**'s reported results and HSAG's calculated findings for each applicable geographic access standard and provider category.

Table C-22—Comparison of Geographic Access Standard Results by Provider Category for UHCCP

Provider Category	Statewide		Frontier		Rural		Urban	
	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)
PCP	100.0%	>99.9%	100.0%	100.0%	100.0%	>99.9%	100.0%	>99.9%
High-Volume Specialists**								
*Cardiology^*	>99.9%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%

Provider Category	Statewide		Frontier		Rural		Urban	
	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)	HSAG Percent Met (%)	MCO Percent Met* (%)
*Neurology^*	>99.9%	99.5%	99.1%	89.4%	100.0%	98.9%	100.0%	100.0%
*OB/GYN^*	100.0%	>99.9%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%
*Oncology-Hematology^*	99.8%	99.6%	98.8%	92.7%	98.9%	98.9%	100.0%	100.0%
*Orthopedics^*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pharmacy	95.8%	95.4%	97.8%	98.1%	93.4%	92.0%	96.3%	96.2%
All Behavioral Health Inpatient and Residential Service Providers†	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	—	—
All Behavioral Health Outpatient Assessment and Treatment Providers	99.9%	99.9%	98.3%	98.5%	>99.9%	>99.9%	>99.9%	>99.9%
Hospitals^	99.2%	99.4%	80.5%	85.7%	99.0%	99.6%	99.9%	99.9%
Optometry	>99.9%	>99.9%	100.0%	100.0%	>99.9%	>99.9%	>99.9%	>99.9%
Ophthalmology	98.2%	98.5%	91.3%	100.0%	100.0%	100.0%	98.1%	98.1%
Dental								
Dentist	>99.9%	>99.9%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Dental Specialists‡								
Oral Surgeon	82.6%	81.8%	22.4%	39.8%	65.2%	64.6%	88.6%	87.2%
Orthodontist	78.4%	75.0%	78.4%	61.1%	58.7%	53.9%	83.0%	80.3%
Periodontist	67.6%	67.9%	0.0%	3.9%	37.5%	37.6%	76.8%	77.1%
Endodontist	67.7%	67.9%	0.0%	0.0%	37.9%	37.9%	76.8%	77.1%
Prosthodontist	67.6%	67.9%	0.0%	0.0%	37.6%	37.8%	76.8%	77.1%
Pediadontist	94.8%	95.1%	86.8%	86.2%	84.4%	85.3%	97.5%	97.7%

*MCO results reflect values submitted to DHHS and HSAG by the MCO, utilizing the template provided to them by DHHS. Results are rounded to the first decimal place. DHHS notes that rates of greater than 99.9 percent are considered to meet the applicable 100 percent standards.
**High-Volume Specialists are those identified by DHHS for purposes of the geographic network distribution analysis.
^Indicates Provider Categories with only Statewide contractual network standards.
†DHHS has established minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Rural and Frontier counties. DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.
— Indicates that no results are available for comparison, as DHHS has not assigned minimum geographic standards for Behavioral Health Inpatient and Residential Service Providers in Urban counties.
‡Please note the MCO does not report results at the urbanicity-level for Dental Specialists. HSAG rolled up Dental Specialists county-level results to report urbanicity-level results.

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

UHCCP identified network adequacy challenges within rural and frontier areas, as well as across dental specialist provider types, which were corroborated by HSAG's time and distance analysis. Where **UHCCP** failed to meet the geographic access standards across dental specialist provider types, HSAG noted a broad range of percent member access. When assessing at the urbanicity level, HSAG's

calculated percentage of members with access for dental specialists ranged from 0.0 percent in frontier areas (Periodontist, Endodontist, Prosthodontist) to 83.0 percent in urban areas (Orthodontist). Please recall that the dental specialist geoaccess standards are assessed by urbanicity, though statewide rates are presented for informational purposes. Table C-18 provides an overview of provider categories and urbanicities for which **UHCCP** did not meet the geographic access standard, with shading to indicate compliance with the geographic access standard.

HSAG recommended that **UHCCP** continue to explore best practices and incentive programs that other organizations may have used to increase access. In addition, **UHCCP** should solicit guidance from DHHS on strategies that could be employed to address gaps in access to care where observed. A list of the specific counties where **UHCCP** did not meet standards is provided in Table C-18, and a list of counties wherein **UHCCP** had received exceptions is provided in Table C-19.

Substantive Findings

HSAG assessed the strengths and opportunities for improvement of each MCO with respect to the quality, timeliness, and accessibility of health care services.

Detailed results from the EQR's substantive findings are summarized in Table C-23 for each activity. This table highlights the extent to which **UHCCP** furnishes high-quality, timely, and appropriate access to health care services, and recommendations for how **UHCCP** can best address opportunities identified for each activity.

Table C-23—UHCCP Substantive Findings Impacting Quality, Timeliness, and Access Domains

Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength: UHCCP** had well-defined processes to maintain accurate and up-to-date provider data, including a quarterly attestation process, system reconciliation, monthly quality assurance reviews, and provider outreach.	🔑
+	**Strength: UHCCP** met the required time and distance standards for PCPs, High-Volume OB/GYN, High-Volume Orthopedics, Pharmacy, All Behavioral Health Inpatient and Residential Services Providers, and Pediadontists across all urbanicities.	🔑
+	**Strength: 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.	🔑

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement:** **UHCCP** failed to meet some time and distance standards in certain urbanicities or statewide for High-Volume Cardiology, High-Volume Neurology, High-Volume Oncology-Hematology, All Behavioral Health Outpatient Assessment and Treatment Providers, Hospitals, Optometry, Ophthalmology, Dentists, Oral Surgeon, Orthodontist, Periodontist, Endodontist, and Prosthodontist provider categories. **Recommendations:** For the provider categories for which **UHCCP** did not meet the time and distance standards, HSAG recommends that **UHCCP** assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify providers in the data using the standard definitions, or other reasons. If the inability to meet the time and distance standard is due to data concerns, **UHCCP** should ensure all providers are appropriately identified in future data submissions.	

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

Table C-24 contains a summary of the follow-up actions that the MCO completed in response to HSAG's CY 2024–2025 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-24—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendation
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 in the Nebraska Contract Year 2024–2025 EQR Technical Report.
Response
Describe initiatives implemented based on recommendations: UHCCP acknowledges the recommendation provided in the EQR Technical Report and remains committed to improving dental network adequacy across urban, rural, and frontier counties. In alignment with the recommendation, UHCCP has implemented the following initiatives: **Targeted Recruitment of Dental Specialists:** UHCCP continues to focus on recruiting dental specialists in high-gap areas, offering competitive fee schedules to attract providers. These efforts are complemented by high-touch provider engagement strategies, including

personalized education and support, to strengthen provider retention and reinforce UHCCP's reputation as a trusted managed care partner.

Identification of General Dentists Performing Specialty Services:
To further address network gaps, UHCCP developed a targeted list of general dentists (GDs) who deliver specialty services such as oral surgery, orthodontics, periodontics, and pedodontics. While these providers may not hold formal specialty credentials, they offer relevant services within their scope of practice. Recognizing and leveraging these providers enhances access to care and supports compliance with network adequacy standards.

These initiatives reflect UHCCP's proactive approach to addressing access challenges and our ongoing commitment to ensuring members receive timely and appropriate dental care, regardless of geographic location.

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

UHCCP has observed measurable improvements in dental network adequacy as a direct result of the initiatives implemented. A comparative analysis of gap counties from the previous and current reporting periods demonstrates meaningful progress:

Total Previous Gap Counties: 446

Total Current Gap Counties: 386

Total Closed Gap Counties: 84

This net reduction reflects UHCCP's continued commitment to expanding access to dental care, particularly in underserved areas. Notably, the most significant improvements were seen in access to orthodontists and pedodontists across both urban and rural counties. These results indicate that our targeted recruitment efforts, provider engagement strategies, and recognition of general dentists performing specialty services are effectively closing network adequacy gaps and improving member access to care.

Identify any barriers to implementing initiatives:

Despite progress, UHCCP continues to face several challenges that impact the full implementation of network adequacy initiatives:

Provider Shortages in Rural and Frontier Areas:
Recruiting dental specialists in low-population regions remains difficult due to limited provider availability, geographic isolation, and a lack of local support services. Many providers prefer to remain in urban areas or operate private practices that do not participate in Medicaid.

Low Provider Participation in Medicaid:
Some providers accept only fee-for-service or commercial insurance and maintain full patient schedules, which limits their interest in joining the Medicaid network.

Credentialing Limitations:
In some academic centers, only the Head of the Department is credentialed, which results in only a limited number of providers being credentialed under certain specialties. However, there are additional qualified providers actively delivering these services to members that are providing services under the supervising specialist. UHCCP continues to explore ways to better reflect the full scope of available providers in the directory and to support accurate network adequacy reporting.

Medicaid Location-Specific ID Requirements:
Nebraska requires providers to obtain a Medicaid ID for each location where they treat members. Many specialists, particularly orthodontists, choose not to register satellite locations where they do not bill directly. As a result, these locations cannot be listed in the provider directory, and UHCCP cannot offer transportation to sites that are not officially recognized within the Medicaid network, even if care is available there.

Identify strategies for continued improvement or overcoming identified barriers:
UHCCP remains committed to addressing the challenges impacting dental network adequacy and has outlined the following strategies to support continued improvement:

Integrating Data Sources to Expand Provider Recognition:
UHCCP is enhancing its data integration efforts by cross-referencing claims data, provider self-attestations, and member feedback. This approach helps identify general dentists who are delivering specialty services within their scope of practice. By recognizing these providers, UHCCP can build a more comprehensive and accurate network of specialty dental care.

Reducing Administrative Barriers for Providers:
To support network growth, UHCCP continues to offer hands-on assistance with Medicaid enrollment and contracting. This includes personalized support to guide providers through the onboarding process, reduce administrative complexity, and strengthen relationships with in-network providers.

Strengthening Academic Partnerships:
UHCCP is actively partnering with Nebraska universities to support the next generation of dental professionals. Through mentorship, education, and early engagement, UHCCP helps new dentists transition into practice by connecting them with community providers or supporting them in establishing their own clinics. This strategy aims to expand the dental workforce pipeline and improve access to care in underserved areas.

These ongoing efforts are designed to address both immediate access gaps and long-term structural challenges, ensuring that members across all regions have equitable access to high-quality dental care.

HSAG Assessment: HSAG acknowledges **UHCCP**'s efforts to maintain and improve access to dental specialist providers in its network.

Network Adequacy Dashboard

Summary

The NAV Dashboard and Saturation Analysis components function primarily as visualization tools that operationalize previously documented NAV results. Accordingly, these components do not generate additional independent findings, nor do they introduce new strengths, opportunities for improvement, or recommendations beyond those delineated in the NAV analytic section.

In collaboration with DHHS, HSAG conducted a detailed review of provider classification methodologies to support cross-MCO comparability. Due to limited or variable state guidance regarding provider categorization, HSAG implemented a standardized classification framework to normalize provider groupings across MCO submissions. This approach necessarily diverged from certain MCO-reported classifications but enabled consistent analytic evaluation across entities.

HSAG presented finalized time and distance results to both DHHS and the MCOs via an interactive Tableau dashboard. The dashboard supports stratified analysis through filters for urbanicity, county, and provider category, enabling granular review of compliance with established network adequacy thresholds. These time/distance components represent the only portions of the NAV Dashboard currently validated for dissemination to DHHS.

For provider types and geographic areas in which MCOs did not meet network adequacy standards, HSAG developed an exploratory, DHHS-only saturation analysis. This analysis identified Medicaid-enrolled providers with comparable service profiles who may serve as potential recruitment targets for strengthening MCO networks. This supplementary analysis was designed exclusively to support DHHS' evaluative and strategic planning processes and is not intended for MCO distribution.

The saturation analysis remains in an early developmental phase. Precision, methodological consistency, and applied utility are still under active refinement with DHHS, and the initial year of results is exploratory. Consequently, there are no substantive findings appropriate for external reporting.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, **UHCCP** did not have prior year's recommendations from the EQRO.

Provider Directory Validation and Secret Shopper Survey

Results

PDV and secret shopper survey results were not final at the time of reporting. Final results from this activity will be included in the CY 2026–2027 EQR Technical Report.

Substantive Findings

HSAG will assess the accuracy of the managed care network information supplied to Heritage Health program members using three sources: the MCOs' provider data files, the MCOs' online provider directories, and secret shopper survey calls to sampled provider locations. Additionally, the secret shopper survey will assess appointment availability and compliance with DHHS' wait time standards.

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

CFR §438.364 requires an assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. However, since this activity is new this CY 2025–2026, **UHCCP** did not have prior year's recommendations from the EQRO.

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 2024 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 IS 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 2024 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 R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.

- A vulnerability management plan is in place to identify security risks to internal systems used for measurement.
- Organization monitors for security risks associated with third-party vendors that may affect measurement.

- Organization considers safeguards to support continued measurement activities following a security event.

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.

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.[20]

Table E-1—Time and Distance Standards by Provider Category and County Urbanicity

Provider Category	County Urbanicity[1]	Geographic Access Standard[2]
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

[20] As listed in Contract Attachment 14: Access Standards – Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 4, 2026.

Provider Category	County Urbanicity[1]	Geographic Access Standard[2]
Behavioral health inpatient and residential service providers	Rural and Frontier	1 provider within 240 miles[3]
Behavioral health outpatient assessment and treatment provider	Urban	2 providers within 30 miles
	Rural	2 providers within 45 miles[4]
	Frontier	2 providers within 60 miles[4]
Hospitals	All counties	1 hospital transport time not to exceed 30 minutes.[5]
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[2]
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 Dec 4, 2025.

[2] Time and distance standards represent driving time and driving distance.

[3] 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.

[4] 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.

[5] 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 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. The standards vary by provider category, as indicated.

Table E-2 presents Physical Health Appointment Availability Access Standards as outlined in Attachment 14: Access Standards.[21]

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.	
Primary Care Practitioners	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.

[21] As listed in Contract Attachment 14: Access Standards – Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 4, 2026.

Appointment Category	Access Standards	
	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.

Table E-3 presents Dental Health Appointment Availability Access Standards as outlined in Attachment 14: Access Standards.[22]

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.

[22] As listed in Contract Attachment 14: Access Standards – Appointment Availability Access Standards. Available at: https://das.nebraska.gov/materiel/purchasing/112209%20O3/Attachment%2014%20-%20Access%20Standards.pdf. Accessed on: Feb 4, 2026.

Appendix F. Activity Timelines

Mandatory Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
PIPs				
Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years	Annual	January 1, 2024–December 31, 2024	MCO submission of PIP Submission Form: April 25, 2025 Initial validation findings and MCO responses: June 23, 2025	Final validation findings provided to DHHS and MCOs: October 27, 2025
Health Risk Screener Completion in Pregnant Members	Annual	January 1, 2024–December 31, 2024	MCO submission of PIP Submission Form: April 25, 2025 Initial validation findings and MCO responses: June 23, 2025	Final validation findings provided to DHHS and MCOs: October 27, 2025
PMV				
HEDIS FARs and IDSS Files	Annual	January 1, 2024–December 31, 2025	Data Request Phase: July 11, 2025 Audit Validation Phase: August 4, 2025 Audit Follow-Up Phase: August 25, 2025 Reporting Phase: August 25, 2025	Data Request Phase: August 1, 2025 Audit Validation Phase: August 22, 2025 Audit Follow-Up Phase: September 5, 2025 Reporting Phase: December 31, 2025

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Assessment of Compliance With Medicaid Managed Care Regulations				
Assessment of Compliance With Medicaid Managed Care Regulations	Annual	January 1, 2024–December 31, 2024	Desk review: June 9, 2025–July 9, 2025 File and webinar review: July 2025 Reporting: July–December 2025	Final reports delivered: December 2025
NAV				
NAV	Annual	Systems and procedures for preceding 12 months. Data as of March 31, 2025.	ISCA submission by MCOs: July 11, 2025 Virtual reviews and system demonstrations: August–September 2025 Validation and report development: August 2025–January 2026	Final report delivered: January 15, 2026

Additional Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Additional Activities				
Network Adequacy Dashboard	Annual	Data as of March 31, 2025	Data submission by MCOs: July 11, 2025 Saturation Analysis: August–September 2025 Validation and Dashboard Development: October 2025–January 2026	Final results delivered in dashboard: January 15, 2026
PDV and Secret Shopper Survey	Annual	Provider network data submitted by the MCOs: September 8, 2025–October 20, 2025	Methodology finalized: August 2025 MCO data received: September–October 2025 Survey field: November–December 2025 Analysis and report development: December 2025–March 2026	Final reports delivered: March 2026
Evaluation of Quality Strategy	Once every three years in accordance with the quality strategy revision cycle	MYs 2024 and 2025 data for some goals and objectives	Information received: July 2025 and March 2026 Evaluation and report development: November 2025–August 2026	Final evaluation report to be delivered: August 21, 2026