IPRO
Improving Healthcare for the Common Good

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2018
Period of Review: September 1, 2017 – March 31, 2018
MCO: Nebraska Total Care

Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Care Management **General Requirements** The MCO must develop a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators.	**Documents** Policy/procedure Program description	Full	This requirement is addressed in NE.CM.01, Care Management Program Description, NE.CM.2.10, Coordination with HCBS Waiver Program and NE.CM.02 Care Coordination Case Management Services.	
The MCO must work with its providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem. Principles that guide this care integration include: 1. The system of care must be accessible and comprehensive, and fully integrate an array of prevention and treatment services for all age groups. It must be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement. 2. Mental illness and substance use disorder are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings. 3. Many people suffer from both mental illness and substance use disorder. As care is provided, both illnesses must be understood, identified, and treated as primary conditions. 4. Relevant clinical information must be accessible to both the primary care and behavioral health providers consistent with Federal and State laws and other	**Documents** Policy/procedure Program description Onsite discussion of how the MCO works with providers to ensure medical/behavioral health care integration and presentation of examples	Full	These requirements are addressed in NE.CM.01. For requirement 4, NTC provided an excerpt from the Provider Manual: Federal and State Laws Government the Release of Information. One role of the care manager is to ensure that all covered services (including physical health, mental health, substance use treatment and/or social services, are available. Members with coexisting medical and behavioral health conditions may have medical and behavioral health care managers assigned with one designated as the lead care manager depending upon the member's primary condition.	

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applicable standards of medical record confidentiality and the protection of patient privacy.				
The MCO must assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition.	**Documents** Policy/procedure Program description	Full	Addressed in NE.CM.01 and NE.CM.02.	
The MCO must incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. CM must engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01 and NE.CM.02. File Review Results Nineteen (19) out of 20 files included self-management strategies. One file was not applicable.	
The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services.	**Documents** Policy/procedure Program description Evidence of identification of members requiring medium/intensive CM based on their chronic conditions	Full	Addressed in NE.CM.01 and NE.CM.02. Levels of care management include care coordination, care management and complex care management. The Smart Start for Your Baby (SSFB) report examples show identification of members with high risk scores based on claims and pregnant members. IMPACTPRO report shows members with chronic conditions and high risk scores.	
The MCO's CM program must address the social determinants of health and how they may affect members' health and wellness. This requirement includes:	**Documents** Policy/procedure Program description Evidence of educating CM staff about available community resources	Full	1. Addressed in NE.CM.01 and NE.CM.02. 2. Addressed in NE.CM.01, NE.CM.02 and NE.CM.17, Women, Infants and Children Supplemental Nutrition Program (WIC) Referrals, CC.CM.03, Abuse and Neglect	

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1. Ensuring that all covered services, including mental health or substance use disorder treatment services, appropriate to a member's level of need, are available when and where the member needs them. 2. Ensuring that all care management staff are familiar with available community resources and will refer members to these resources, such as, but not limited to, housing assistance programs and shelters, food banks/pantries, educational opportunities, and organizations which can assist with and address physical and/or sexual abuse. 3. Developing, subscribing to, or acquiring a tool accessible to its care management staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO shall make access to this information available to MLTC staff on request.	View community resource tool/directory onsite		Reporting, 2018 Resource Guide and Resources for Care Management. 3. Addressed in NE.CM.01, NE.CM.02, 2018 Resource Guide and Resources for Care Management. Staff sign-in sheets provided for Resource Guide, Glossary and Service Comparison training. NTC also provided transcripts for individual staff showing completed training modules.	
A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained about how social determinates affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, and violence. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.	**Documents** Evidence of MCO staff training including agendas, meeting materials and attendance records	Full	NTC provided screenshots of Krames and MyStrength Resources from the NTC website that is available to members. NTC also provided Medical Management training sign-in sheets and attendance records for Lunch & Learn staff trainings. Minutes for behavioral health case management, case management, LifeShare IDD program and NTC IDD program team meetings were provided. NTC provided training slides for social determinants of health and care planning.	

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The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.	**Documents** Policy/procedure Program description	Full	Addressed in NE.CM.01.	
As part of the CM system, the MCO must employ care coordinators and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to a member.	**Documents** Position descriptions for care coordinator and care manager Organizational chart for CM department	Full	NE.CM.01 includes organization structure and composition of care teams. The NTC organizational chart for medical management was also provided.	
The MCOs must submit policies and procedures specific to care management for individuals who are dually eligible, have adult-onset disabilities, developmental disabilities and/or otherwise receive institutional or community-based long-term supports and services that address the unique needs of these populations.	**Documents** Policies/procedures	Full	Addressed in NE.CM.01, NE.CM.02, NE.CM.2.10, Coordination with HCBS Waiver Program and NE.CM.02.04, Special Health Care Needs.	
In addition, the MCO must annually review, and update as necessary, with the input, review, and approval of the Clinical Advisory Committee (CAC), the CM policies and procedures. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.	**Documents** Evidence of CAC approval of CM policies and procedures Evidence of MCO staff training including agendas, meeting materials and attendance records Evidence of sharing policies/procedures with providers	Full	Clinical Advisory Committee (CAC) meeting minutes for January 16, 18 demonstrate review of CM policies and procedures. Staff training records were provided such as sign-in sheets and attendance records. The 2017 and 208 Clinical Provider Training Reports were provided. Some of the trainings included care management-related topics such as integrated care. Presentation slides for provider town hall meetings were also provided.	

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			The complex care management program is described in the Provider Manual.	
Health-Risk Screening/Assessment The MCO must provide a health-risk screening to all members on enrollment to identify members in need of CM services.	**Documents** Policy/procedure Template screening instrument **Reports** Examples of CM reports showing completion rates by new enrollees	Full	Addressed in NE.CM.01 and NE.CM.01.04, New Member Welcome Call and health risk assessment tool. NTC also provided a screenshot of the Health Risk Screen for Members on the MCO website. The welcome page invites members to complete a health risk screening on the member portal or by calling the number provided to complete the assessment within 30 days and obtain a CentAccount award.	
As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of CM services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral	**Documents** Policy/procedure Member Handbook Provider Manual	Full	Addressed in NE.CM.01, NE.CM.02, Health Risk Screen for Members on the MCO's website, health risk assessment tool and the Provider Manual Case Management Referrals page on the MCO website.	

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Health-risk assessments must be developed to collect information such as, but not limited to: 1. Severity of the member's conditions/disease state. 2. Co-morbidities, or multiple complex health care conditions. 3. Recent treatment history and current medications. 4. Long-term services and supports the member currently receives. 5. Demographic and social information (including ethnicity, education, living situation/housing, legal status, employment status, food security). 6. Activities of daily living (including bathing, dressing, toileting, mobility, and eating). 7. Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation). 8. Communication and cognition. 9. Indirect supports. 10. General health and life goals. 11. Safety (need for welfare/protection to eliminate harm to self or others).	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01, NE.CM.02 and the health risk assessment tool. File Review Results Twenty (20) of 20 files reviewed included a health risk assessment.	

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12. The member's current treatment providers and care plan, if applicable. 13. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma. 14. Substance use, including alcohol. 15. Interest in receiving CM services.				
The MCO must assign members to risk stratification levels (low, medium, high), which determines the intensity of intervention levels and follow-up care required for each member.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Prior Results (2017) Substantial-16 of 20 files included a risk stratification level, 3 files did not include a risk stratification level, and 1 file was not applicable. MCO Response NTC agrees with findings. NTC provided staff education multiple times during start up and then additional training based on internal audit findings. Additionally the expectation is reinforced during team meetings throughout the year. Addressed in NE.CM.01, NE.CM.02, health risk assessment tool and Integrated Care Management (ICM) Playbook. NTC also provided an example of a case summary with acuity score/risk stratification. File Review Results Twenty (20) of 20 files reviewed included a risk stratification level.	
The MCO must ensure that members who have high costs or potentially high costs, or otherwise qualify, be	**Documents** Policy/procedure	Full	Addressed in NE.CM.01, NE.CM.02, health risk assessment tool and ICM Playbook. NTC also	

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assigned to the medium or high risk level and receive more intensive CM services.	Onsite presentation of case assigned to medium or high risk level based upon high costs or potentially high costs		provided an example of a case summary with acuity score/risk stratification. A report of high cost members with high cost conditions was provided.	
The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.	**Documents** Policy/procedure	Full	Addressed in NE.CM.01, NE.CM.02, health risk assessment tool and ICM Playbook.	
The MCO must conduct ongoing predictive modeling to identify members who may need CM evaluation.	**Documents** Policy/procedure **Reports** Examples of predictive modeling reports	Full	Addressed in NE.CM.01and NE.CM.02. The following reports also demonstrated use of predictive modeling to identify members: High cost members with high cost conditions, SSFB reports and IMPACTPRO report of chronic conditions-high risk.	
Behavioral Health Principles of Care The MCO must ensure that "active treatment" is being provided to each member. Active treatment includes implementation of a professionally-developed and supervised individual plan of care, in which the member participates and shows progress.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01, NE.CM.02 and care plan example. File Review Results Twenty (20) of 20 files included an individual plan of care.	
Basic CM Services The MCO must develop and adopt a CM program consistent with existing State policies and procedures to ensure all members who are eligible for CM have access to basic CM services.				
The MCO's basic CM program must promote empowerment of the person and shared decision making. Examples of basic level CM services the MCO may provide include:	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01and NE.CM.02. File Review Results Two (2) of 20 files reviewed met the requirement and 18 files were not applicable.	

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1. Assistance with appointment scheduling and identifying participating providers, when necessary.				
2. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01and NE.CM.02. File Review Results Eight (8) of 20 files reviewed met the requirement and 12 files were not applicable.	
3. Coordination of discharge planning with a focus on the seriously mentally ill population.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01, NE.CM.02 and EPC.UM.219, Standards for Discharge Planning. File Review Results Seven (7) of 20 files reviewed met the requirement and 13 files were not applicable.	
4. Coordination that links a member to providers, medical services, or residential, social, community, and other support services, when needed.	**Documents** Policy/procedure Program description	Full	Addressed in NE.CM.01and NE.CM.02.	
5. Continuity of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of care activities must provide processes by which MCO members and network/non-network provider interactions are effective and must identify and address those that are not.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Prior Results (2017) Substantial-5 of 20 files provided evidence of collaboration, 1 file did not provide evidence of collaboration, and 14 files were not applicable. MCO Response NTC agrees with these findings. NTC provided staff education multiple times during start up and then additional training based on internal audit findings. Additionally the expectation is reinforced during team meetings throughout the year.	

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			Addressed in NE.CM.01, NE.CM.02, EPC.UM.219 and NE.UM.20, Continuity and Care Coordination of Services. File Review Results Seventeen (17) of 20 files reviewed met the requirement and 3 files were not applicable.	
6. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.	**Documents** Policy/procedure Program description **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01, NE.CM.02, Resource Guide and Resources for Care Management. File Review Results Fourteen (14) of 20 files reviewed met the requirement and 6 files were not applicable.	
7. Following up with members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.	**Documents** Policy/procedure Program description Examples of follow-up with members and providers	Full	Addressed in NE.CM.01 and NE.CM.02.NTC also provided member and provider newsletters posted to the NTC website and Member Connections Outreach Scheduled Events calendar.	
The MCO must develop and adopt policies and procedures annually to address the following: 1. A strategy to ensure that all members and/or authorized family members or guardians are involved in care planning, as appropriate.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01 and ICM Model Playbook. File Review Results Twenty (20) of 20 files reviewed met the requirement.	
2. A method to actively engage members in need of CM who are unresponsive to contact attempts or disengaged from CM.	**Documents** Policy/procedure Onsite discussion of methods used	Full	Addressed in NE.CM.01. Files reviewed also demonstrated follow-up of members that were difficult to contact or disengaged from care management.	
3. An approach that uses pharmacy utilization data to tailor CM services.	**Documents** Policy/procedure	Full	Addressed in NE.CM.01, NE.CM.02 and NE.CM.18, Restricted Services Program (Lock-In). The Medication Adherence Program	

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	Evidence of using pharmacy utilization data to tailor CM services		includes pharmacy project reports such as psychotropic medications for youth. NTC also provided sample provider-specific pharmacy reports. Files reviewed also demonstrated use of IMPACTPRO to obtain member's medication history and claims.	
4. An approach to encourage participation in CM activities by, and collaboration among, the following providers: a. PCPs and behavioral health providers. This includes policies that ensure that PCPs refer members to behavioral health specialists when SMI is present or the member identifies as having a SMI. b. HCBS service coordinators. c. Community support providers.	**Documents** Policy/procedure Description of approach for encouraging participation in CM activities and collaboration among providers	Full	a. Addressed in NE.CM.01, Provider Manual and Provider Psychiatric Assistance Line. b. Addressed in NE.CM.02.10, Coordination with HCBS Waiver Programs. c. Addressed in NE.CM.01 and NE.CM.02.10.	
5. Procedures and criteria for making referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must (a) provide the coordination necessary for referral of MCO members to specialty providers to determine the need for services outside the MCO network and (b) refer a member to the appropriate service providers.	**Documents** Policy/procedure	Full	Addressed in NE.CM.02.	
6. Results of the identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated and to identify any	**Documents** Policy/procedure	Full	Addressed in NE.CM.01and NE.CM.02.	

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ongoing special conditions that require a course of treatment or regular care monitoring.				
7. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.	**Documents** Policy/procedure	Full	Addressed in NE.CM.02.	
8. Documentation of referral services and medically indicated follow-up care in each member's medical record.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	Addressed in NE.CM.01. NTC also provided a case example showing care manager notes regarding member follow-up care. This requirement is also addressed in the Provider Manual and the MCO website, under Provider Communication- Medical Record.	
9. Documentation in the member's medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.	**Documents** Policy/procedure Provider communication regarding medical record documentation	Full	Addressed in NE.CM.01. NTC also provided a case example showing care manager notes regarding member follow-up care. This requirement is also addressed in the Provider Manual and the MCO website, under Provider Communication- Medical Record.	
10. A process that ensures that when a provider is no longer available through the MCO, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional 90 calendar days to ensure continuity of care.	**Documents** Policy/procedure	Full	Addressed in NE.UM.20, Continuity and Coordination of Services and NE.CM.02.	
11. A process that ensures continuity of care for members with SHCNs who are in CM.	**Documents** Policy/procedure	Full	Addressed in NE.CM.02.04, Special Health Care Needs and NE.CM.02.	
For members assigned to medium risk care management, the MCO must meet basic care management requirement and: 1. Facilitate relapse prevention plans for members with depression and other high-risk behavioral health	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.02. File Review Results Eight (8) of 20 files reviewed met the requirement and 12 files were not applicable.	

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conditions and their PCPs (e.g., patient education, extra clinic visits, or follow-up telephone calls).				
2. Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.	**Documents** Policy/procedure Onsite discussion	Full	Prior Results (2017) Substantial- This requirement is addressed in NE.CM.02, Care Coordination Case Management Services. The MCO has not yet identified provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence. MCO Response NTC agrees with the findings. NTC will work with our pharmacy vendor and data analytic to identify the two groups based on the drug utilization rates and then strategies used for successful adherence. Addressed in NE.CM.02. NTC is conducting a pharmacy project, Use of Psychotropics in Youth that includes identification and sharing of best practices to achieve higher medication adherence rates.	
3. Educate provider office staff about symptoms of exacerbation(s) and how to communicate with patients.	**Documents** Policy/procedure Examples of education provided to office staff	Full	Addressed in NE.CM.02 and Clinical Practice Guidelines. The Provider Manual directs providers to the NTC website for information on clinical practice guidelines. Provider practice guidelines are available on the NTC website and include topics such as preventative care for adults, children/adolescents, lead screening; perinatal care; disease management for asthma, COPD, diabetes; and behavioral health conditions (ADHD, major depressive disorder).	

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4. Develop speaking points and triggers for making emergency appointments.	**Documents** Policy/procedure Onsite discussion	Full	Addressed in NE.CM.02, Clinical Practice Guidelines and Krames on Demand.	
5. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors, or unmet needs.	**Documents** Policy/procedure Examples of forms and monitoring tools	Full	Addressed in NE.CM.01 and NE.CM.02. The case management team completes assessments such as the HRA, PHQ-9, and/or Notification of Pregnancy (NOP) which give the case managers scores to help determine acuity/level of case management required. Nurtur (disease management program) provides materials related to asthma, COPD, diabetes, heart disease, heart failure, tobacco cessation, and weight management. MyStrength is available for behavioral health members and Krames on Demand provides educational materials for members.	
For members assigned to high risk care management, the MCO must meet requirements for members assigned to low and medium risk care management and the MCO must develop and adopt policies and procedures for the following: 1. As appropriate, organize the care using a person-centered, inter-disciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, that are in accordance with State QI and UM standards.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.02. File Review Results Seven (7) of 20 files reviewed met the requirement and 13 files were not applicable.	
2. Provide list of community resources (for referral).	**Documents** Policy/procedure **Onsite File Review**	Full	Addressed in NE.CM.01, NE.CM.02, Resource Guide and Resources for Care Management. File Review Results	

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	CM file review results		Six (6) of 20 files reviewed met the requirement and 14 files were not applicable.	
3 Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.	**Documents** Policy/procedure	Full	Addressed in NE.CM.02 and NE.CM.02.10.	
4. Develop a process to engage non-compliant members.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01 and NE.CM.02. File Review Results Eleven (11) of 20 files reviewed met the requirement and 9 files were not applicable.	
5. Develop a strategy for communication with members and their families, as well as key service and support providers and local social and community service agencies.	**Documents** Communication strategy	Full	Addressed in NE.CM.02.	
6. Identify providers with special accommodations (e.g., sedation dentistry).	**Documents** Policy/procedure Provider directory	Full	Addressed in NE.CM.02 and NTC Provider Directory on the MCO website.	
7. Educate staff about barriers members may experience in making and keeping appointments.	**Documents** Evidence of staff education	Full	Prior Results (2017) Substantial- Staff training documents provided do not address barriers members may experience in making and keeping appointments. MCO Response NTC agrees with the findings. NTC is evaluating the training materials and we have found that the materials address barriers members experience and will develop specific education information on keeping appointments.	

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			Addressed in the Centene Community Health training course.	
8. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use.	**Documents** Policy/procedure Onsite discussion	Full	Addressed in NE.CM.02. For individual members, NTC conducts multidisciplinary rounds and Member Connections representatives conduct home visits. The MCO maintains clinical practice guidelines for perinatal care, diabetes and tobacco cessation. NTC participates in community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, and Reading Events.	
9. Communicate on a member-by-member basis on gaps/needs to ensure that a member obtains baseline and periodic medical evaluations from his/her PCP.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.02. File Review Results Nine (9) of 20 files reviewed met the requirement and 11 files were not applicable.	
The MCO must develop, implement, and evaluate written policies and procedures consistent with existing State policies and procedures, regarding continuity of care. In particular, the policies and procedures must address the following situations: 1. Members whose treating providers become unable to continue service delivery for any reason. 2. Member transitions from the children's system to the adult system. 3. Member transitions to/from IHS or other tribal agencies.	**Documents** Policies/procedures	Full	1. Addressed in NE.UM.20. 2. Addressed in NE.UM.20 and NE.CM.15, Coordination with Division of Children and Family Services. 3. Addressed in NE.CM.14, Coordination with Tribal Organizations, and NE.UM.20. 4. Addressed in NE.UM.20.	

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Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
4. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.				
Coordination with Providers and Other CM Programs Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other State programs are likely to have one or more case or care managers. The MCO must demonstrate an understanding of health care and social service programs and initiatives offered by MLTC and other State agencies, and leverage those programs when appropriate for members receiving medium and intensive CM. Leveraging of existing programs may take the form of subcontracting or highly collaborative partnering, for example, and is intended to take advantage of existing resources and infrastructures to reduce or eliminate duplication of effort. Highly collaborative partnering must include, but is not limited to, crisis response services in coordination with behavioral health system entities.	**Documents** Policy/procedure Onsite discussion	Full	Addressed in NE.CM.01, NE.CM.02, NE.CM.02.10, Resource Guide and Resources for Care Management.	
The MCO must attempt to ascertain whether a member has any other case or care managers, and, if so, to engage with them. The MCO must also attempt to ascertain whether a member has any other identified caregivers in the member's care planning and CM, and, if so, to engage with them.	**Documents** Policy/procedure **Onsite File Review** CM file review results	Full	Addressed in NE.CM.01, NE.CM.02 and NE.CM.02.10. File Review Results Two (2) of 20 files reviewed met the requirement and 18 files were not applicable.	
The MCO is responsible for ensuring coordination between its providers and the WIC program.	**Documents** Policy/procedure	Full	Addressed in NE.CM.17, Women, Infants, and Children Supplemental Nutrition (WIC) Referrals, NE.CM.01 and NE.CM.02.	

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Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.			NTC program specialists work with providers on a case-by-case basis to ensure referrals to the WIC program.	
The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.	**Documents** Policy/procedure Onsite discussion	Full	Addressed in NE.CM.02 and NE.UM.20.	
Coordination with HCBS Service Coordinators The MCO must collaborate and coordinate with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports. The MCO must develop a policy and procedures for coordination with HCBS case managers. This policy and these procedures must address methods the MCO will use to ensure that coordination services are not duplicated.	**Documents** Policy/procedure	Full	Addressed in NE.CM.02.10, NE.CM.01 and NE.CM.02.	

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State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with Tribal Organizations The MCO must develop policies for care coordination/collaboration for members who are Tribal members or are eligible for care through IHS or other Tribally-funded health and human services program, including: 1. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes. 2. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network. 3. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally-operated facility/ program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638. 4. Development of methods for regular planning to coordinate on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate health service delivery.	**Documents** Policy/procedure	Full	1. Addressed in NE.CM.01 and NE.CM.14. NTC has a dedicated tribal liaison. 2. Addressed in NE.CM.14 and the Provider Manual. Community health workers work with tribal representatives and attend events to explain NTC benefits. 3. Addressed in NE.CM.14. 4. Addressed in NE.CM.14. NTC also provided Tribal Health Advisory Committee meeting minutes.	

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Care Management				
State Contract Requirements Federal Regulations 438.208	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Coordination with the Division of Children and Family Services The MCO must develop processes and procedures for collaboration with the Division of Children and Family Services for children who are in foster care placement. CM must include collaborating with the child's Children and Family Services Specialist and identifying and responding to a child's health care needs including behavioral health. Policies and procedures must include: a. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice. b. How health needs identified through screenings will be monitored and treated. c. How medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record. d. Steps to ensure continuity of health care services. e. The oversight of prescription medications.	**Documents** Policy/procedure	Full	Addressed in NE.CM.15. Addressed more generally in NE.CM.02 and NE.CM.01.	

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Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Provider Network Requirements **General Provider Network Requirements** The network must be supported by written contracts between the MCO and its providers.	**Documents** Template provider contract – one per provider type	Full	This requirement is addressed in the Participating Provider Agreement.	
The MCO must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in the Provider Manual. Page 13 of the Provider Manual states that Medicaid providers "Offer hours of operation no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members".	
There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.	**Documents** Policy/procedure	Full	This requirement is addressed in policy NE. CONT 01 "Network Adequacy".	
The MCO must have available non-emergent after-hours physician or primary care services within its network.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	During the onsite review, the MCO's website was reviewed to address the requirement of available non-emergent after-hours physician or primary care services within its network.	
Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in Attachment 39 – Revised Access Standards. The MCO must ensure that providers are available within these requirements. **Attachment 39:** Appointment Availability Access Standards	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no service gaps were identified.	

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State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas. 2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO. 3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation. 4. Family planning services must be available within seven calendar days. 5. Non-urgent, preventive care must be available within 4 weeks. 6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week. 7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.				

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Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care. 9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists. <u>Geographic Access Standards</u> 1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members in urban counties; one PCP within 45 miles of the personal residences of members in rural counties; and one PCP within 60 miles of the personal residences of members in frontier counties. 2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics. 3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.				

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State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences. b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences. c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences. 4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC. 5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.				

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6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census. 7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.				
The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements.	**Documents** Policy/procedure	Full	The MCO provided policy NE.CONT.01 which describes their monitoring activities and gap solutions in cases where access cannot be met. NE PRVR.06 describes Corrective Action policy that will be taken if providers fail to meet the access requirements.	
The MCO must make a good faith effort to contract with urgent care centers in the State to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	During the onsite review, the MCO noted all good faith efforts have been made to contract with all Urgent Care Centers in the State. The MCO noted barriers with those urgent care centers resistant to contract with Medicaid MCOs. It is recommended that the MCO continue to ensure efforts to pursue all urgent care centers within the State, and continue to document these efforts and the barriers encountered.	
In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to	**Documents** Policy/procedure	Minimal	Language not limiting providers from contracting with another MCO could not be	

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providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.	Template provider contract – one per provider type Provider manual		located in policy NE.CONT.01, or in the provider contract. **Recommendation** NTC should update policy NE.CONT.01 and the provider contract to include language to meet this requirement. **MCO Response** NTC agrees with findings. **IPRO Final Findings** No change in review determination.	
The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters.	**Documents** Template provider contract – one per provider type Provider manual	Full	This requirement is addressed in policy NE.QI 26 describes the MCO's cultural competency requirements which are stated in the Provider Manual (pages 23 and 24).	
The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	This requirement is addressed in the MCO's Cultural Competency policy, and also evident within the provider directory on NTC's website.	
The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.	**Documents** Policy/procedure Provider directory Onsite discussion	Full	During the onsite review, the MCO's website was reviewed. This requirement is addressed within the provider directory on NTC's website.	
Provider Discrimination Prohibition A MCO may not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider	**Documents** Policy/procedure Provider manual	Full	Policy NE PRCN 05 which describes the MCO's non-discrimination policy addresses this requirement.	

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who/that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification.				
MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Documents** Policy/procedure Provider manual	Full	Policy NE PRCN 05 describes the MCO's non-discrimination policy regarding high risk populations and costly treatment.	
If a MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements at 42 CFR 438.12(b) shall not be construed to: 1. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members. 2. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. 3. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to its members.	**Documents** Policy/procedure	Full	Policy NE.PRCN.05 includes the languages regarding the declining of providers in its network.	
Mainstreaming of Members To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status,	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Substantial	The MCO has a policy NE.CONT.03 regarding non-discrimination of Indians, however, this policy does not include all State Contract Requirements. During the onsite review, the MCO provided additional evidence of addressing non-discrimination in the PPA Contract, as well as in	

Provider Network Requirements				
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
sexual-orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f): 1. Denying or not providing a member any covered service or access to an available facility. 2. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary. 3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service. 4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.			the Welcome Kit to new members. However, evidence of all State Contract Requirements could not be found in the Provider Manual or Member Handbook. **Recommendation** NTC should update their policy to include each of the contract requirements. Additionally, the MCO should update the Provider Manual and Member Handbook to include the contract requirements. **MCO Response** NTC agrees with findings. While NE.CONT.03 is specific to the Indian population, NE.PRCN.05, also supplied, speaks to non-discrimination across the entire network. **IPRO Final Findings** No change in review determination. IPRO recommends the MCO to update policy NE.PRCN.05 to include contract requirements.	

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If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full	Evidence to meet this requirement could not be located in the documentation provided. **Recommendation** The MCO should update their documentation to include this standard in their Network Development and Management Plan. In addition, discouraging barriers to care should be stated in the Provider Manual and/or provider contract. **MCO Response** NTC disagrees with findings. This language is in the Provider Contract, section 3.3 (page 6) Shared Savings exhibit (page 156) and the HBR exhibit (Page 164). **IPRO Final Findings** After review of the MCO response and the documents provided (namely, NE NTC- PPA – 12.7.17), the review determination has been changed from non-compliance to full.	
If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.	**Documents** Policy/procedure	Full	This requirement is addressed in policy CR.04 Addressing Identified Instances of Potentially Discriminating Practices (pages 2 and 3).	
Establishing the Network The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format	**Documents** Policy/procedure	Full	The MCO's Network Adequacy Policy (NE CONT 01) describes actions it will take to ensure network adequacy.	

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approved by MLTC, to demonstrate it meets this requirement at contract start date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.			During the onsite review, the MCO advised that no gaps in care were identified during the review period.	
The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.	**Documents** Policy/procedure Onsite discussion	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no service gaps were identified.	
The MCO must provide an adequate network of (PCPs) to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician	**Documents** Policy/procedure	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no service gaps were identified.	

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assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.				
The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members. In addition, the MCO must make a good faith effort to include providers currently contracted with behavioral health regions in Nebraska.	Onsite discussion	Full	During the onsite review, the MCO advised that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no service gaps were identified.	
The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.	**Documents** Policy/procedure Member Handbook	Full	The Member Handbook (pages 36, 37, 69) includes information about women's health care and access to routine and preventive care.	
For members who meet SHCN criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	**Documents** Policy/procedure Member Handbook	Full	The Member Handbook (page 49) includes information about access for members with special needs.	
The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions: 1. Co-occurring mental health and substance use disorders.	**Documents** Policy/procedure Onsite discussion	Substantial	The MCO's Network Adequacy Policy (NE_CONT-01) describes its behavioral health network; however the policy does not include the behavioral l health conditions specified in the standard. During the onsite review, the MCO's behavioral health Provider Directory was viewed on the website to address this requirement.	

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2. Co-occurring mental health and substance use disorders and developmental disabilities. 3. Serious and persistent mental illness. 4. Severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities, etc.). 5. Sex-offending behaviors. 6. Eating disorders. 7. Co-occurring serious mental illness (SMI) and common chronic physical illnesses.			**Recommendation** The MCO should update the policy to specify the behavioral health conditions described in the state contract. **MCO Response** NTC agrees with findings. NE.CONT.01 has been updated to include this language. **IPRO Final Findings** No change in review determination.	
If any service or provider type is not available to a member within the mileage radius specified in Attachment 39 – Revised Access Standards, the MCO must submit to MLTC, for approval a minimum of 45 calendar days prior to implementation, verification that the covered services are not available within the required distance.	**Documents** Policy/procedure Examples of notification to MLTC	Full	The MCO's Network Adequacy Policy (NE_CONT-01) describes its gap report and states that it will be shared with DHHS. During the onsite review, the MCO advised that no gaps in care were identified during the review period.	
The MCO is not precluded from making arrangements with a provider outside the State for members to receive a higher level of skill or specialty than the level that is available within the State.	**Documents** Policy/procedure	Full	The MCO's policy CC-UM 17 documents single case agreements (SCA) with non-participating health care providers authorized to provide covered services to health plan members or services not addressed in the participating provider contract.	
Contracting with FQHCs and RHCs	**Reports** Geo access reports	Full	NTC's Network Development Plan notes that their network encourages relationships with	

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A MCO must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.	Onsite discussion		FQHCs. The MCO's Q4 GeoAccess report indicates it contracts with the Medicaid FQHCs in urban regions of the State. For RHCs, the MCO contracts with several in each region of the state, though there are counties without RHCs in the network. During the onsite review, the MCO advised that they are contracted with all RHCs and FQHCs.	
Adequate Capacity When establishing and maintaining the network, the MCO must consider: Its anticipated Medicaid enrollment. The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. The numbers of network providers who/that are not accepting new Medicaid patients. The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	**Documents** Policy/procedure Network development plan Onsite discussion	Full	The MCO's Network Development Plan addresses this requirement.	

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Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.				
Appointment Availability and Referral Access Standards Nebraska's appointment availability standards are included in Attachment 39 – Revised Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 38 – Revised Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.				
Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Substantial	The MCO's NE PRVR 06 policy includes the 45 minute wait time standard. The provider contract (page 24 – NTC PPA) states 45 minutes, however the Provider Manual (page 18) states one hour. Similarly, the Member Handbook states one hour as well. **Recommendation** The MCO should update the Provider Manual and Member Handbook to reflect the 45 minute requirement. **MCO Response** NTC agrees with findings. **IPRO Final Findings** No change in review determination.	

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Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	The MCO's Provider Manual states that hospitals must "Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit". The Provider Manual should be broadened to meet the language of the standard.	
Direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number at any time. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual Member Handbook	Full	The Member Handbook (page 10) includes the toll-free number: Member Services and 24/7 free nurse advice 1-844-385-2192. Policy NE.UM.01 states that members accessing care with contracted providers do not require a referral from their PCP nor an assessment.	
The MCO is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment availability including results and f/u actions	Full	Policy NE/PRVR.06 defines the Accessibility Standards applicable to the MCO's Contracted Providers and describes the methods used by the health plan to monitor the accessibility standards and ensure that they are maintained.	
The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCOs.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment "no-show" rate including results and f/u actions	Full	Prior Results(2017) Substantial- Onsite it was discussed that case management logs 'no shows' in its records. The provider network department does not monitor 'no show' rates. MCO Response NTC agrees with these findings and it is developing a process to appropriately monitor "no show" rates by provider and service type. Based upon the findings of last year's audit, the MCO developed Policy NE PRVR 53 to outline	

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			process for monitoring and reducing No-Show appointments.	
The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual **Reports** Evidence of monitoring of waiting lists including results and f/u actions	Full	Prior Results (2017) Substantial- The provider network department does not monitor the practice of placing members who seek any covered services on waiting lists. MCO Response NTC agrees with these findings and it is developing a process to appropriately monitor waiting lists rates by provider and service type. Based upon the findings of last year's audit, the MCO developed monthly Wait and Ward reports.	
Geographic Access Standards The MCO must comply with maximum travel times and/or distance requirements per Attachment 39 – Revised Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	**Documents** Policy/procedure Requests for exception submitted to MLTC **Reports** Evidence of Geo access monitoring including results and f/u actions	Full	During the onsite review, the MCO indicated that MLTC initiated a new provider network template to be used beginning January 1, 2018. After review of the 1st quarter 2018 report, no service gaps were identified.	
If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the	**Documents** Policy/procedure Provider network availability plan	Full	The MCO has developed a Provider Network Availability Plan to monitor gaps and take corrective action, when warranted.	

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circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.				
The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.	**Documents** Policy/procedure Provider network availability plan **Reports** Evidence of monitoring utilization including results and f/u actions	Full	The MCO maintains a Network Development Plan to ensure that its network is sufficient to meet the access needs of all its members. In addition, NE.PRVR.06 states that NTC will establish, maintain and monitor outreach efforts made to the health plan's rural/frontier provider network.	
Provider Credentialing and Re-Credentialing The MCO is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.	**Documents** Policy/procedure	Full	The MCO's policy CC.CRED.01 addresses this requirement for the credentialing and re-credentialing process.	
The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must: 1. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or 2. Deny the application and ensure that the provider is not used by the MCO. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.	**Documents** Policy/procedure Template denial letter	Full	The MCO has three policies (CC.CRED.01, CC.CRED.04 and CC.CRED.06) that include the various components of the credentialing standard.	

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A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.				
The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO must also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.	**Documents** Policy/procedure	Full	The MCO's CC.CRED.01 policy (page 79) includes the language regarding the Affordable Quality Healthcare system. The policy states it will also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development.	
The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.	**Documents** Policy/procedure **Onsite file review** Credentialing file review results	Full	The MCO's CC.CRED.01 policy states that the standards include practices for practitioner credentialing, re-credentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA). File Review Results Ten (10) of 10 files met this requirement.	
The MCO must re-credential each provider a minimum of every three (3) years, at a minimum, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information.	**Documents** Policy/procedure **Onsite file review** Re-credentialing file review results	Full	According to the plan's CC.CRED.01 policy, the certificate is valid for three (3) years from date of issuance for physicians and one (1) year for non-physician mid-level practitioners. File Review Results	

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			Re-credentialing file review was not applicable, as there were no providers re-credentialed during the review period.	
The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.	**Documents** Policy/procedure	Full	According to the MCO's CC.CRED.06 policy, they will communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.	
Network Administration The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider: 1. Network provider name 2. Contracted services 3. Site address(as) (street address, city, zip code, region of the State) 4. Site telephone numbers 5. Site hours of operation 6. Emergency/after-hours provisions 7. Professional qualifications and licensing; 8. Areas of specialty, including specialties related to behavioral health conditions 9. Cultural and linguistic capabilities	**Documents** Policy/procedure View network provider database onsite	Full	The MCO's provider directory policy, CC.PRVR.26 includes most of the elements in the standard. During the onsite review, the MCO's online directory, and the MCO's Portico Provider Data Management System was reviewed and met the requirements. Updates to the web-based provider directory are automated from the Portico system, to keep all data current.	

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

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Quantitative data, including performance of appointment standards/appointment availability, eligibility/enrollment data, utilization data, network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case contracts by service type.				
Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses.	**Documents** Policy/procedure Network development plan	Full	The MCO's Provider Grievance Tracking Log Report monitors grievances.	
Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review.	**Documents** Policy/procedure Network development plan	Full	The MCO's Provider Network Development Plan monitors network issues and provides for corrective actions, when warranted.	
A summary of network development efforts conducted during the prior year.	**Documents** Policy/procedure Network development plan	Full	The MCO's Network development Plan and Network Adequacy policy, NE.CONT.01, state the actions the MCO takes to ensure network adequacy.	
Plans to correct any current material network gaps and barriers to network development.	**Documents** Policy/procedure Network development plan	Full	The MCO's Network Development Plan includes gap report activities.	
Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities.	**Documents** Policy/procedure Network development plan	Full	The MCO's Network Development Plan includes priority areas for focused efforts.	

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The participation of members, family members/caretakers, providers, including State-operated providers, and other community stakeholders in the annual network planning process.	**Documents** Policy/procedure Network development plan	Full	The MCO's Network Development Plan includes provision for members and their families in the network planning process.	
Provider Network Policies and Procedures The MCO must have policies about how it will: Communicate with the network regarding contractual and/or program changes and requirements.	**Documents** Policy/procedure	Full	Policy NE.PRVR.52 outlines the MCO's process for notifying contracted providers of a material change in operations or in the Nebraska Total Care provider network.	
Monitor network compliance with State rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes.	**Documents** Policy/procedure	Full	Policy NE.PRVR.03 Provider Complaints was provided as evidence to address this requirement.	
Evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full	Policy NE.QI.13 sets forth the MCO's policy on medical record standards for providers.	
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.	**Documents** Policy/procedure	Full	Policy CC.UM.17 (Single Case Agreements) sets forth the MCO's process for providing single case agreements with non-participating health care providers authorized to provide covered services to health plan members or services not addressed in the participating provider contract.	
Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.	**Documents** Policy/procedure	Full	Policy NE.CONT.01 (Network Adequacy) describes the MCO's process for establishing, maintaining and monitoring a network of affiliated providers that is sufficient to provide adequate access to all covered services.	

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Process provisional credentials for behavioral health service providers.	**Documents** Policy/procedure	Full	Policy CC.CRED.01 sets forth the MCO's Practitioner Credentialing & Re-credentialing process. All types of providers are covered in the policy. However, a credentialing process for behavioral health providers is not specifically noted. **Recommendation** It is recommended that NTC's policy be amended to include a provisional credentialing process for behavioral health providers. **MCO Response** NTC disagrees with findings. Per Policy CC.CRED.01 the provisional credentialing process is included (page 5). From page 3: Types of Practitioners: The credentialing/recredentialing processes apply, but are not limited to, the following practitioner types: Medical doctors (MD); Nurse Practitioners (NP); Oral surgeons (DDS/DMD); Chiropractors (DC); Osteopaths (DO); Podiatrists (DPM); Behavioral Health Service Providers; and Mid-level practitioners (non-physician). From page 5: Provisional Credentialing: Credentialing and the Plan may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for	

Provider Network Requirements				
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			provisional credentialing is only available to practitioners who are applying for the first time to the Plan practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days **IPRO Final Findings** After review of the MCO response and the documents provided, the review determination has been changed from minimal to full.	
Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling.	**Documents** Policy/procedure	Full	Policy CC.CRED.01 was provided as evidence to address this requirement.	
Provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full	The MCO has an extensive provider training program, which is described in policy NE.PRVR.50 and an orientation program in NE.PRVR.13. The MCO's website also includes a provider training page.	
Educate its provider network regarding appointment time requirements.	**Documents** Policy/procedure	Full	NE.PRVR.06 describes the MCO's adequacy process. The results of its access and availability calls are tracked and used to identify providers who may need education and/or corrective action plans (CAPs) to bring them into compliance with the MCO's appointment accessibility standards.	
Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.	**Documents** Policy/procedure **Reports**	Full	Policy NE.PRVR.03 Provider Complaints was provided as evidence to address this requirement.	

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	Evidence of tracking/trending of provider inquiries/complaints/requests for information including results and f/u actions		The MCO provided grievance-related materials it has developed, including: Provider Grievance and Tracking Log Report; Provider Grievance Acknowledgement Letter Provider Grievance Inquiry Letter; and Provider Grievance Resolution Letter	
Provider-Patient Communication/Anti-Gag Clause Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following: a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the member needs in order to decide among relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1) will be subject to intermediate sanctions.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	Policy NE.CONT.50 Patient-Provider Communications includes the language in the standard. A non-discrimination section is included in the MCO's Provider manual (page 37).	

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The MCO must comply with the provisions of 42 CFR 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to physician incentive plans.				
Confidentiality The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	Confidentiality and adherence to HIPAA is stated in the Provider Contract template. HIPAA and privacy laws are referenced in the Provider Manual.	

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Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Provider Complaint System A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the MCO, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by the MCO. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.	**Documents** Policy/procedure	Substantial	NTC provided NE.PRVR.03, Provider Complaints. This policy/procedure was discussed during the onsite review. Although titled Provider Complaints, this policy/procedure addresses: claims adjustment/claim complaints, provider complaints, grievances filed on behalf of a member and appeals. It was strongly recommended that NTC develop separate policies/procedures for these topic areas. As it is currently written, the provider complaint process lacks clarity and timeframes are inconsistently described. For example, element 2, Provider Complaints, states that the provider will receive written resolution of the complaint from the claims department within 30 business days of the receipt of the complaint. Element 3, Process for submitting a Provider Grievance/Complaint states a resolution timeframe not to exceed 90 calendar days. The NTC tracking log report notes a 60 day turnaround time. It is also noted that the Provider Manual includes a 90-day resolution timeframe. The MCO clarified that resolution timeframe for claims adjustment/claim complaints is 30 days and that the resolution timeframe for non-claims complaints is 60 days. The 90 –day timeframe is applicable to grievances filed on behalf of a member. The policy/procedure for provider complaints should also distinguish between a provider complaint and a provider grievance. NTC also	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			explained that complaints received and resolved by phone are not considered grievances and are not collected for provider complaint reporting. The circumstances for characterizing a complaint as a grievance and for including complaints in reporting should also be explained in the policy. The provider complaint policy/procedure should also describe how complaints from out-of-network providers are handled. **Recommendation** NTC should develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request and for resolution. The criteria used to define a provider complaint versus a provider grievance should be documented including how each is tracked and reported. The provider complaint policy/procedure should also describe how complaints from out-of-network providers are handled. **MCO Response** NTC agrees with findings. A revision to PR.VR.03 was completed on 6/20/2018 and approved by the health plan that took into account the feedback from IPRO and made it	

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Provider Services				
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			more clear and explicit to provider complaints. Additionally, updated provider grievance and appeal letters were created to accompany the policy. **IPRO Final Findings** No change in review determination.	
This system must be capable of identifying and tracking complaints received by telephone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.	**Documents** Policy/procedure **Reports** Provider complaint system reports produced during the review period	Full	Addressed in NE. PRVR.03. Provider Grievance and Tracking Log Report includes, for example, tracking ID#, complaint type, date files, acknowledgment date, resolution date, provider demographic information, description of response. The MLTC-approved log does not collect method of request, e.g., verbal, however this information is noted in the individual case files.	
The MCO must prepare and implement written policies and procedures that describe its provider complaint system. The policies and procedures must include, at a minimum: 1. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes. 2. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function.	**Documents** Policy/procedure Provider manual Template complaint resolution notice **Onsite File Review** Provider complaint file review results	Substantial	NE. PRVR.03 provided. 1. Addressed in policy/procedure but resolution timeframes are discrepant as noted above. 2. This requirement is not addressed in NE.PRVR.03. Per NTC, providers may file a complaint for any reason with MLTC. NTC should confirm this understanding with MLTC and address the requirement in policy. 3. NTC did not provide a description of how provider services staff are trained.	

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3. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf. 4. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues. 5. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation. 6. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary. 7. A process for giving providers (or their representatives) the opportunity to present their cases in person. 8. Identification of specific individuals who have authority to administer the provider complaint process. 9. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.			4. Addressed in NE.PRVR.03 and Provider Alerts, posted on the NTC website. 5. Addressed in NE.PRVR.03. 6. Addressed in NE.PRVR.03. 7. NE.PRVR.03 allows for providers to provide complaints/grievances to any NTC staff member while the staff is meeting with the provider outside of NTC premises. 8. Addressed in NE.PRVR.03. 9. NTC records provider complaints in its customer relationship management system. Associated documentation is maintained in the case file. NTC submitted the following template letters. The Provider Grievance Acknowledgment Letter addresses member grievances not provider complaints. Likewise, the template Grievance Inquiry Letter is related to member grievances not provider complaints. NTC explained that these templates are used for both member and provider grievances. The templates apply to member grievances filed by members or providers filing on behalf of a member but not for provider complaints. NTC should develop separate template letters for each type: provider complaint, provider grievance, member grievance and grievance filed by the provider on the member's behalf.	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			The template Provider Grievance Resolution Letter includes language that if not satisfied, a provider can request a 2nd review by MCO QM staff. This second level of review is not addressed in other documents provided including the policy/procedure, Provider Manual and website. File Review Results A total of 10 files were reviewed. All files were completed timely and included documentation of investigation of the substance of the complaint. **Recommendation** NTC should develop separate policies/procedures for member grievances, grievances filed on behalf of a member, provider complaints, provider grievances and appeals. Each policy/procedure should include the relevant timeframes for making a request, acknowledging a request and for resolution. NTC should develop separate template letters for member grievances, grievances filed on behalf of a member, provider complaints, and provider grievances. NTC should confirm with MLTC the circumstances upon which providers may file a complaint directly with MLTC for those issues that are not a MCO function and document this in policy.	

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State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			NTC should maintain a description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf and provide evidence of this training during future compliance reviews. Language found within the Provider Grievance Resolution Letter template (regarding a 2nd review by MCO QM staff if provider not satisfied with 1st review) should also be included in the MCO's policy/procedure, Provider Manual and website. **MCO Response** NTC agrees with findings. A revision to PR.VR.03 was completed on 6/20/2018 and approved by the health plan that took into account the feedback from IPRO and made it more clear and explicit to provider complaints. Additionally, updated provider grievance and appeal letters were created to accompany the policy. NTC has also completed a revised Provider Manual for 2018 with updates. Provider Services training protocols and documentation have been identified based on feedback. **IPRO Final Findings** No change in review determination.	

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Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.	**Documents** Policy/procedure Provider manual View website onsite	Substantial	The Provider Manual is included on the NTC website. The website also includes a discrete section titled Grievance Process. Both are included under the heading of Provider Resources. The Provider Manual includes the provider's right to make a complaint. Under a section titled Member Grievances, both member grievances and provider complaints are described. It is noted that the process is the same for both. The discrete section titled Grievance Process refers to member grievances only. Contact information for provider services staff is included on the MCO website and in the Provider Manual. **Recommendation** The NTC Provider Manual and website should include separate descriptions and instructions for member grievances, grievances filed on behalf of a member, provider complaints, provider grievances and appeals. NTC should ensure consistency across policies/procedures, the Provider Manual and the website. **MCO Response** NTC agrees with findings. The MCO has completed a revised Provider Manual for 2018 with updates and will ensure posting of	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			relevant material to website upon the revised Provider Manual's approval by MLTC. **IPRO Final Findings** No change in review determination.	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Subcontracting Requirements As required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3), the MCO is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to: The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	**Documents** Policy/procedure List of subcontractors including scope of services provided and date of initial delegation **Reports** Pre-delegation evaluation report for each subcontractor contracted with during the review period Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Substantial- NTC provided a list with 18 active subcontracts. One of these, Bankers Life Insurance is a reinsurance contract, not a subcontractor and has been removed from the review universe leaving 17 for review. Of the 17 contracts, only 10 had effective dates in the review period. Nine (9) of 10 met this requirement. One (Morpace) was effective 3/6/17 however no evidence of pre-delegation evaluation was provided. MCO Response The 2016 audit summary for Morpace has been added to the IPRO FTP. This should meet the requirement of a pre-delegation evaluation for this subcontractor. NTC provided a list of 17 subcontractors. All were continuing contracts from prior years. No new contracts were entered into that would require pre-delegation evaluation. NTC provided Policy CC.COMP.43, Policy CC.COMP.43.05 as well as their Vendor Risk Assessment policy which contain sections on compliance with standard contract language, pre-delegation and ongoing monitoring.	
The MCO must have a written contract between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	**Documents** Contract with each subcontractor Also includes reviewer completion of subcontractor worksheet	Full	Seventeen (17) of 17 subcontractors have contracts in place that meet all requirements.	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Minimal- Ten (10) out of 17 subcontractors met this requirement. There was no evidence provided of ongoing monitoring for 7 subcontractors: Aarete, Altegra, Equian, Krames, Morpace, Rawlings, and SPH Analytics. MCO Response NTC will establish ongoing and annual reviews of all subcontractors' performance and share results at NTC's quarterly Quality Management Committee meetings. NTC will maintain an annual audit schedule and convene a Vendor Management Committee to meet annually to review the results of each vendor audit. Draft Vendor Audit committee Report on Annual Vendor Audit was presented. NTC provided quarterly vendor oversight reports presented to the QAPI committee for four quarters. Two were within the review period. All 17 subcontractors were subject to ongoing monitoring. FORMAL ANNUAL REVIEW Based on the Annual Vendor Audit Report, 6 of 17 subcontractors underwent formal annual review. An additional 7 were listed as reviewed in the report but with dates in 2016 or earlier. The risk based vendor audit documents were reviewed, as well as a list of 2016-17 vendor	

Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			audits. Five (5) vendors were listed as being in risk categories that did not warrant audits. (Rawlings Group, Aarete, Equian, , Cotiviti, and CDR). The MCO stated during onsite discussion that the State reviewed and approved their vendor management plan and risk tier approach and that MLTC has approved the policies and therefore the methodology. Discussion also centered on NCQA guidelines. A subsequent search took place for any published guidelines related to the risk tier approach and no source for corroboration has been found. **Recommendation** The MCO should perform a formal evaluation of vendor performance a minimum of once per year. **MCO Response** NTC disagrees with findings. Evidence of MLTC approval of policy and procedure CC.COMP.21.07 Vendor Risk Assessments which details audit frequency is based on risk level of the vendor was submitted to IPRO on 5/17/2018. 2017 annual audit results for National Imaging Associates were also submitted on 5/17/18. NTC located these submissions under Onsite Request/Subcontracting. **IPRO Final Findings**	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			IPRO has re-visited the documentation related to Risk Based vendor assessments. MLTC did in fact provide approval of policy CC.COMP.21.07. While IPRO believes annual monitoring is the best practice, the MCO has complied with its approved policies and therefore this element is deemed to be fully compliant.	
If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	Prior Results (2017) Minimal- Ten (10) out of 17 met this requirement. Because the MCO did not provide evidence of any monitoring for 7 subcontractors (listed above), it was impossible to tell if any of those would have contained corrective action plans and effective follow-up. MCO Response NTC will establish ongoing and annual reviews of all subcontractors' performance and share results at NTC's quarterly Quality Management Committee meetings. The final report at the end of each year will capture the subcontractors' performance for each month. NTC will maintain an annual audit schedule and convene a Vendor Management Committee annually to review the results of each vendor audit. Seven (7) of the 17 subcontractors had performance deficiencies identified during ongoing monitoring. Seven (7) of 7 subcontractors that warranted corrective action and follow-up received the required oversight.	

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Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Member Rights and Protections **Member Rights** The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC 7-001. At a minimum, each MCO member is guaranteed the right to: a. Be treated with respect and consideration of his/her dignity and privacy. b. Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information. c. Participate in decisions regarding his/her health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO. d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. e. Request and receive a copy of his/her medical records, and request that they be amended or corrected as specified in 42 CFR 438.100. f. Obtain available and accessible health care services covered under the contract. g. Request disenrollment per 42 CFR 438.56.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Member Handbook, pages 67-71; and on the member website, under "Member Rights and Responsibilities."	

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Member Services and Education				
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Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the Member Handbook under "Member Rights," page 68, bullet 25.	
Indian Health Protections Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, the MCO must: Permit any American Indian who is enrolled in a MCO and eligible to receive services from a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his/her PCP, as long as that provider has the capacity to provide the service. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.	**Documents** Policy/procedure **Reports** Provider adequacy report for I/T/U providers	Substantial	Prior Results (2017) Substantial- The first part of this requirement is addressed in the policy and procedure Coordination with Tribal Organization. This policy also delineates that one of the responsibilities of the tribal liaison is to inform the MCO's Networking Department about I/T/U providers who are in demand by members, but are not part of the MCO's provider network to "encourage network participation" (page 2), which pertains to item ii of this requirement. However, the MCO did not provide any reports that evidence that provider adequacy for the I/T/U providers is being tracked or measured. MCO Response NTC is currently contracted with every I/T/U provider available in the state of Nebraska, there is no room for expansion on I/T/U provider network. NTC is at 100% network participation of eligible providers. IPRO Response Evidence of tracking/measuring I/T/U provider adequacy to ensure timely access should be submitted for the 2018 compliance audit. The first part of this requirement is addressed in policy/procedure NE.CONT.03; and in the Member Handbook on page 18.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			The second part of this requirement is partially addressed. While NTC provided IPRO with what seems like a map of Nebraska's I/T/U provider network across all counties, the map is difficult to interpret without a key. IPRO requested a key for the map on multiple occasions. Onsite, the MCO stated a key would be uploaded to the FTP site, however it was not uploaded. **Recommendation** IPRO recommends the MCO provide a map key or explanation of the I/T/U provider coverage map on the next compliance review so that it can be interpreted accurately. **MCO Response** NTC disagrees with findings; the legend to the map was provided in a separate document titled Attachment 3 – Nebraska Counties Classification which is located under the Provider Network folder. **IPRO Final Findings** No change in review determination. The map titled "Attachment 3—Nebraska Counties Classification" depicts the distribution of rural, frontier, and urban counties throughout the state of Nebraska, but does not depict the adequacy of I/T/U provider coverage in Nebraska.	

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Notice to Members of Provider Termination The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.	**Documents** Policy/procedure Template notice of provider termination	Full	This requirement is addressed in the Member Handbook on page 40 "What to do if your PCP Leaves Our Network"; and the template of notice of provider termination titled "C_NTC TermNotice_PCP_member."	
The MCO must provide notice to a member who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change, if the notice is provided in advance.	**Documents** Policy/procedure Template notice of provider termination	Full	This requirement is addressed in policy/procedure NE.MBRS.27, page 1, under "Timely Notice."	
Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.MBRS.27, page 1, under "Failure to Receive Prior Notice."	
Oral Interpretation and Written Translation Services	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.MBRS.02, page 1, policy statement; Member Website, under "Language	

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In accordance with 42 CFR 438.10(b)(1), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the State. The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member. This applies to all non- English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately.			Assistance"; "NE_BableSheet_NonDisc_NMP"; and in the Member Handbook on pages 5-9.	

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Requirements for Member Materials The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.MBRS.02.	
The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.MBRS.02, page 2.	
The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website.	**Documents** Policy/procedure Member materials for new members	Substantial	The first part of this requirement is addressed in policy/procedure NE.MBRS.04, page 1, Procedure 6. The second part of this requirement is partially addressed in the documentation provided. The verbiage for this requirement is not presented on the member info sheet that was provided titled "LotA_WL_NewMember-2048637-1_Proof1". There is only verbiage explaining that if the member has questions, they can call member services. Information about the NTC member website and what is on the website is found on page 19 of the Member Handbook, however there is no verbiage which explains how the member can obtain written materials if they do not have access to the website. **Recommendation** The MCO should provide members with information on how to obtain written materials if the member does not have access to their website.	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			MCO Response NTC agrees with findings. Member Handbook has been updated to provide additional options to members on how they can obtain information besides the NTC site. NTC is awaiting MLTC approval of Member Handbook. **IPRO Final Findings** No change in review determination.	
Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.	**Documents** Policy/procedure	Full	Prior Results (2017) Substantial- This requirement is partially addressed in the Member Materials Readability and Translation Policy and Procedure pertaining to readability, oral interpretation, and language translation of member materials (pages 1 and 2). However, the policy does not include alternative formats, such as Braille, large print and audio. The MCO has a comprehensive 2-page (1 sheet) Language Sheet and Statement of Non-Discrimination which, on one side, informs members that information in their language is available and free of charge (and informs them of how to obtain translation services), and on the other side informs members that they can obtain oral interpretation services as well as "written information in other formats (large print, audio, accessible electronic formats, other formats)." During the onsite visit, the MCO demonstrated that this sheet is included in communications with members, including in the welcome packet and multi-page	

Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			communications such as denial letters. This sheet of information is also included in the Member Handbook. The Member Handbook informs the members that the handbook itself is available in large print, Braille, audio CD, and different languages on page 5. MCO Response The Language Sheet and Statement of Non-Discrimination will be included as an attachment to policy NE.MBRS.02. This requirement is addressed in policy/procedure NE.MRKT.01, page 2, section C; policy/procedure NE.MRKT.14, page 1, purpose statement and policy statement; the Statement of Non-Discrimination document titled "NE_BableSheet_NonDisc_NMP"; and in the Member Handbook and member website accessibility report. The Language Sheet and Statement of Non-Discrimination has been added as an attachment to policy NE.MBRS.02, as demonstrated onsite, as of 4/17/18.	
All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.MBRS.02 on page 1, in the Member Handbook on pages 5-6, and within NTC's website on the language assistance webpage.	
The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.	**Documents** Policy/procedure Examples of member materials in English and Spanish, such as newsletters and other informational materials	Full	This requirement is addressed in policy/procedure NE.MBRS.02, pages 1-2; NTC Spanish webpages; NTC Member Handbook Spanish Version, and the new member brochure titled "LotA_WL_NewMember-2048637-1_Proof1".	

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Member Services and Education				
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.	**Documents** Policy/procedure	Substantial	The MCO provided examples of written materials such as: Member Handbook, Statement of non-discrimination, member brochure, and annual member mailing. These are all clearly legible on the computer screen, however it is difficult to determine the font size, as these documents are in PDF format and screenshots of the website. This requirement is not included in the policy/procedure provided. Onsite, the MCO stated all materials are at least 12-point font and that Word document versions of the documents would be uploaded as additional documentation. No such documentation was uploaded. **Recommendation** NTC should specify the minimum font size of member materials in a policy/procedure, and provide materials that are in a Word document format for the next compliance review. **MCO Response** NTC agrees with findings. The MCO has communicated and updated in the policy and procedure manual of the required 12 Font size for all member materials given. **IPRO Final Findings** No change in review determination.	
The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be	**Documents** Policy/procedure Sample marketing materials	Full	This requirement is addressed in the following examples of marketing materials provided by	

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prominently displayed on all marketing materials, including the cover of all multi-page materials.			NTC: member ID card, member brochure, and Member Handbook (on the back cover).	
All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.	**Documents** Policy/procedure Examples of member materials	Full	This requirement is addressed in policy/procedure NE.MBRS.02, policy statement; the Member Handbook on pages 5-6; and the babble sheet that and non-discrimination form that is included in all member mailings titled "NE_BableSheet_NonDisc_NMP".	
All written materials related to MCO enrollment and PCP selection must advise members to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.	**Documents** Policy/procedure Member materials for new members	Full	This requirement is addressed in the Member Handbook on pages 37-42.	
Member Handbook The MCO must develop, maintain, and post to the member portal of its website a Member Handbook in both English and Spanish. The MCO must publish the Member Handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy Member Handbook if they want it. At a minimum, the MCO must review and update the Member Handbook annually The MCO's updated Member Handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the MCO must provide members written notice of	**Documents** Policy/procedure Member Handbook View website onsite Onsite discussion	Full	This requirement is addressed in policy/procedure NE.MRKT.21; and English and Spanish versions of Member Handbook via NTC's website. Onsite, the MCO demonstrated how a member would sign into the member portal. Locating and accessing the Member Handbook was demonstrated, both in English and Spanish. The statement of non-discrimination and language assistance information sheets are available on the bottom of every webpage, which states that the member can call the MCO with questions about the Handbook. MCO staff confirmed that the member can call the MCO and request a hard copy of the Handbook. IPRO brought to the MCO's attention that there is a link of page 11 of the Member Handbook which is accompanied by	

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the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.			verbiage that describes the secure member portal on the NTC website. However; the link is actually the NTC website homepage. IPRO suggests that the link is directed instead directly to the member portal login page.	
At a minimum, the Member Handbook must include: 1. A table of contents.	**Documents** Member Handbook should address all sub-elements	Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure; and in the Member Handbook on pages 1-3.	
2. A general description of basic features of how MCOs operate and information about the MCO in particular.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure; and in the Member Handbook on page 4.	
3. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The Member Handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.		Full	This requirement is addressed in the Member Handbook on page 11.	
4. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure; and in the Member Handbook on page 55, major life changes and on pages 69-70.	
5. Member rights/protections and responsibilities.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 2; and in the Member Handbook on pages 67-70.	

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6. Appropriate and inappropriate behavior when seeing a MCO provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on page 14 and page 70.	
7. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the Member Handbook.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 5-9.	
8. A description of the PCP selection process and the PCP's role as coordinator of services.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 37-40.	
9. The member's right to select a different MCO or change providers within the MCO.		Full	This requirement is addressed in the Member Handbook on pages 36-38 and pages 56-58.	
10. Any restrictions on the member's freedom of choice of MCO providers.		Full	This requirement is addressed in the Member Handbook on pages 57-58.	
11. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 12-13.	
12. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 14-18.	
13. Procedures for obtaining benefits, including authorization requirements.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under	

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			procedure, page 1; and in the Member Handbook on pages 14-18, and 31-32.	
14. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.		Full	This requirement is addressed in the Member Handbook, pages 30-31 and 35.	
15. Information about health education and promotion programs, including chronic care management.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook, pages 48-50.	
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 33-35.	
17. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".		Full	This requirement is addressed in the Member Handbook, pages 38-39 and 70.	
18. Information about a member's right to a free second opinion and how to obtain it.		Full	This requirement is addressed in the Member Handbook on page 33, under "Second Medical Opinion".	
19. The extent to which, and how, after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition, emergency services, and post-stabilization services. b. That prior authorization is not required for emergency services.		Full	This requirement is addressed in policy/procedure NE.MRKT.21, under procedure, page 1; and in the Member Handbook on pages 32-36.	

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c. The process and procedures for obtaining emergency services, including use of the 911-telephone system. d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.				
20. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.		Full	This requirement is addressed in the Member Handbook, pages 22-28.	
21. How to obtain emergency and non-emergency medical transportation.		Full	This requirement is addressed in the Member Handbook, page 28.	
22. Information about the EPSDT program and the importance of children obtaining these services.		Full	This requirement is addressed in the Member Handbook, pages 26-28.	
23. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care.		Full	This requirement is addressed in the Member Handbook, pages 46-48.	
24. Information about member copayments.		Full	This requirement is addressed in the Member Handbook, page 51.	
25. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.		Full	This requirement is addressed in the Member Handbook, pages 55-56.	
26. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the MCO's contract with		Full	This requirement is addressed in the Member Handbook, page 18.	

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MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection.				
27. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.		Full	This requirement is addressed in the Member Handbook, page 69.	
28. Member grievance, appeal, and state fair hearing procedures and timeframes, as follows: a. For grievances and appeals: i. Definitions of a grievance and an appeal. ii. The right to file a grievance or appeal. iii. The requirements and timeframes for filing a grievance or appeal. iv.. The availability of assistance in the filing process. v. The toll-free number(s) the member can use to file a grievance or an appeal by telephone. vi. The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.		Full	This requirement is addressed in the Member Handbook, pages 62-66.	

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b. For state fair hearing: 1. Definition of a state fair hearing. 2. The right to request a hearing. 3. The requirements and timeframes for requesting a hearing. 4. The availability of assistance to request a fair hearing. 5. The rules on representation at a hearing. 6. The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.		Full	This requirement is addressed in the Member Handbook, page 66.	
29. A description of advance directives that includes: a. The State's and MCO's policies about advance directives. b. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.		Full	This requirement is addressed in the Member Handbook, pages 60-62; and on the member website "Advance Directive" webpage.	
30. Information about how members can file a complaint with MLTC or the Division of Public		Full	This requirement is addressed in the Member Handbook, pages 61-62.	

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Health about a provider's failure to comply with advance directive requirements.				
31. How a member may report suspected provider fraud and abuse, including but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose.		Full	This requirement is addressed in the Member Handbook, page 67.	
32. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the MCO. b. The MCO's physician incentive plan (42 CFR 438.6(h)). c. The MCO's service utilization policies. d. How to report alleged marketing violations to MLTC. e. Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.		Substantial	This requirement is partially addressed in the Member Handbook, page 4, pages 30-35, and pages 66-67. There was no verbiage in the Member Handbook stating the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state. **Recommendation** The MCO should add verbiage to the Member Handbook which states the member could get additional information about the MCO physician incentive plan and reports of transactions between the MCO and parties of interest provided to the state. **MCO Response** NTC agrees with findings. **IPRO Final Findings** No change in review determination.	
33. A minimum of once a year, the MCO must notify members of the option to receive the		Minimal	The MCO provided the annual member mailing as documentation for this requirement. The mailing seems to be a brochure titled "NTC-	

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Member Handbook and the provider directory in either electronic or paper format.			NE_Member brochure_20170601, with ACCESSNebraska", which does not have verbiage that describes to the member that they have the option to receive the Member Handbook and provider directory in paper or electronic format. This information was also not found in the Member Handbook. **Recommendation** The MCO should provide members with written notification at least once a year that states that they can receive the Member Handbook and provider directory in paper or electronic format. **MCO Response** NTC agrees with findings. Notifications will be sent out to all members via mail at least annually. **IPRO Final Findings** No change in review determination.	
Other Member Notifications The MCO must also provide the following information to each member: A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.	**Documents** Policy/procedure Evidence of member notification	Minimal	The MCO provided the annual member mailing as documentation for this requirement. The mailing seems to be a brochure titled "NTC-NE_Member brochure_20170601, with ACCESSNebraska", which does not have verbiage that describes to the member that they have the right to disenrollment from the MCO. The website was also provided as documentation, however this does not satisfy the requirement that states that members must be notified annually.	

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			Onsite, the MCO stated additional documentation would be provided which satisfies this requirement, however no such documentation was provided. **Recommendation** The MCO, at a minimum of annually, should provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period. **MCO Response** NTC agrees with findings. Notifications will be sent out to all members via mail at least annually. **IPRO Final Findings** No change in review determination.	
A minimum of annually, the MCO will inform all members of their right to request the following information. 1. An updated Member Handbook, at no cost to the member. 2. An updated provider directory, at no cost to the member.	**Documents** Policy/procedure Evidence of member notification	Minimal	The MCO provided the annual member mailing as documentation for this requirement. The mailing seems to be a brochure titled "NTC-NE_Member brochure_20170601, with ACCESSNebraska", which does not have verbiage that describes to the member that they have the option to receive the Member Handbook and provider directory at no cost to the member. Onsite, the MCO stated additional documentation would be provided which satisfies this requirement, however no such documentation was provided. **Recommendation**	

Member Services and Education				
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			The MCO should inform members of the right to obtain the Member Handbook and Provider Directory at no cost. **MCO Response** NTC agrees with findings. Notifications will be sent out to all members via mail at least annually. **IPRO Final Findings** No change in review determination.	
Member Newsletter The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to: 1. Educational information on chronic illnesses and ways to self-manage care. 2. Behavioral health information. 3. Reminders of flu shots and other prevention measures at appropriate times. 4. Medicare Part D issues. 5. Cultural competency issues. 6. Tobacco cessation information and programs. 7. HIV/AIDS testing for pregnant women. 8. Other topics as requested by MLTC.	**Documents** Policy/procedure copies of member newsletters issued during the review period	Full	This requirement is addressed on the NTC member website, on the member newsletter webpage. Onsite, the MCO mentioned 2 newsletters that are being readied for distribution on the member website. Per the MCO, their goal is to upload the newsletter quarterly.	
Provider Directory for Members The MCO must develop and maintain a provider directory for its members in three (3) formats:	**Documents** Policy/procedure Provider directory	Full	This requirement is addressed in policy/procedure NE.PRVT.19: Provider Directory – Portico; and the provider directory webpage on the NTC website.	

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1. A hard copy directory, when requested, for members, potential members, and the enrollment broker. 2. A web-based, searchable, online directory for members, potential members, and the general public. 3. An electronic file of the directory to be submitted and updated weekly to MLTC or its designee, and the enrollment broker.	View website onsite		Onsite, the MCO demonstrated finding a behavioral health provider in a rural area. The search included location, language spoken by the office and provider, office hours, and if the provider is accepting new patients.	
The hard copy directory for members must be updated a minimum of monthly. The web-based version must be updated in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.PRVT.19: Provider Directory – Portico.	
In accordance with 42 CFR 438.10(f)(6), the provider directory must include, but not be limited to: 1. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers who/that are not accepting new patients must be identified. 2. Hours of operation, including identification of providers with non-traditional hours (before	**Documents** Policy/procedure Provider directory View website onsite	Full	This requirement is addressed in the provider directory PDF document; and policy/procedure NE.PRVT.19: Provider Directory – Portico. Onsite, the MCO demonstrated finding a behavioral health provider in a rural area. The search included location, language spoken by the office and provider, office hours, and if the provider is accepting new patients.	

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8 am, after 5 pm, or any weekend hours).				
Member Website The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the MCO and receive responses). The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. Use of proprietary items that would require use of a specific browser or other interface is not allowed.	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed on the "About Us" webpage of the member website; and policy/procedure CC.MRKT.14: Website 508 Compliance. Onsite, the MCO demonstrated a member finding a behavioral health provider in a rural area. The search included location, language spoken by the office and provider, office hours, and if the provider is accepting new patients.	
The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:	**Documents** Policy/procedure View website onsite	Full	This requirement is addressed on the following webpages of the member website: Homepage, "Why Nebraska Total Care?" "What is Heritage Health?" "Resources" "Find a Provider" "How to Enroll" and "Complaints-appeals".	

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1. The most recent version of the Member Handbook. 2. Telephone contact information for the MCO, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number. 3. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the MCO network. 4. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment. 5. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. 6. Information about how to file grievances and appeals.				
Advance Directives The MCO must maintain written policies and procedures for advance directives. The MCO must provide written information to all adult members with respect to: 1. Their rights under applicable law. 2. The MCO's policies respecting the implementation of those rights, including a	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure "CC.CM.10 Advance Directives".	

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statement of any limitation regarding the implementation of advance directives as a matter of conscience. The MCO is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health. Any written information on advance directives must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of a change.				

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Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Quality Management The MCO must include QM processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The MCO's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system as a result of this RFP. The MCO will be provided with the final Quality Strategy when it is approved by CMS. The MCO must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities.				
The MCO's QM program must include: 1. A quality assurance and performance improvement (QAPI) program. 2. Performance improvement projects (PIPs). 3. Quality performance measurement and evaluation. 4. Member and provider surveys.	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	

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5. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program.				
The MCO must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.	**Documents** QM Program Description Corporate organizational chart QM department organizational chart	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17. QAPI Committee Charter and NTC Org Chart also provided.	
Quality Management Deliverables The MCO must submit the following QM deliverables to MLTC: Description and composition of the QAPI Committee (QAPIC).	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	
A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes. QM Program Description due date: 30 calendar days following 12th month of contract year	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17. Evidence of timely submission to MLTC was provided.	
A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QM activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to: 1. Data collection and analysis. 2. Evaluation and reporting of findings.	**Documents** QM work plan	Full	This requirement is addressed in the NE.QM Workplan 2017. Evidence of timely submission to MLTC was provided.	

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3. Implementation of improvement actions, where applicable. 4. Individual accountability for each activity. QM work plan due date: 30 calendar days following 12th month of contract year				
Procedures for remedial action for deficiencies that are identified.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 and in NE.QI.02 QM Program Operations 11092017.	
Specific types of problems requiring corrective action.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 and in NE.QI.02 QM Program Operations 11092017.	
Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 and in NE.QI.02 QM Program Operations 11092017.	
Procedures for provider review and feedback about results.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/0/17 and in NE.QI.02 QM Program Operations 11092017.	
Annual QM evaluation that includes: 1. Description of completed and ongoing QM activities. 2. Identified issues, including tracking of issues over time.	**Documents** QM Evaluation Onsite discussion	Full	This requirement is addressed in the NTC QI Program Evaluation 2017 – approved on 2/6/18. Evidence of timely submission to MLTC was provided.	

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3. Analysis of and tracking progress about implementation of QM goals and the principles of care, as appropriate. Measurement of and compliance with these principles must be promoted and enforced through the following strategies, at a minimum: a. Use of QM findings to improve practices at the MCO and subcontractor levels. b. Timely reporting of findings and improvement actions taken and their relative effectiveness. c. Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website. d. Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions. e. An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program. QM Evaluation due date: 30 calendar days following 12th month of contract year			NTC has submitted an application for accreditation in December 2017 for First Accreditation survey in January 2019.	

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Procedures assessing the quality and appropriateness of care furnished to members with SHCNs. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.	**Documents** QM Program Description Policy/procedure	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 and in NE.QI.02 QM Program Operations 11092017.	
QAPI Program The MCO's QAPI program, at a minimum, must comply with State and Federal requirements (including 42CRF 438.204) and UM program requirements described in 42 CFR 456. The QAPI program must: Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC.	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	
At a minimum, assess the quality and appropriateness of care furnished to members.	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	
Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	
Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by the State's Quality Strategy. All collected data must be available to the MCO and MLTC.	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	
Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually.	**Documents**	Full	Prior Results (2017) Substantial- The language for this requirement is found in NTC's QAPI Program Description,	

Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Evidence of providing information about the QAPI program to members and providers		page 38. For providers, information about the QAPI program can be found on NTC's website, as well as within the Provider Manual, which also references the QAPI Committee (QAPIC), and notifies providers about the opportunity to participate in this committee. Information regarding the QAPI program can be found on the Member Resources page of the NTC website. The Member Handbook contains a broad description of the QI Program. MCO Response NTC is continuously evaluating the website and materials to ensure completeness of information. Information about the Quality Program and how to contact the plan with quality improvement opportunities has been added to the Member website and revisions to the Member Handbook will be forthcoming. Goals and progress on the goals will be added to the webpage once HEDIS rates are complete. This requirement is addressed in the 2018 Member Handbook, under Quality Improvement Program (pages 58-59). In addition to an overview of the program, the MCO updated the Member Handbook to include the following: **How to get involved:** We want your involvement. Let us know how we are doing. Or, you can help us by being a member of one of our Quality Committees.	

Quality Management				
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			Call Member Services. The phone number is 1-844-385-2192, TTY: 1-844-307-0342, Relay 711.You can send us a letter. The address is: Nebraska Total Care Attention: Quality Improvement 2525 N. 117th Ave, Suite 100 Omaha, NE 68164 **Annual Evaluation** To meet our goals we look at how well we are serving you each year. We also look for ways to do things better. Every year we write a report about our quality program. You can read that report on our website NebraskaTotalCare.com. If you want more information about our Annual Evaluation and Quality Plan call Member Services. The phone number is 1-844-385-2192, TTY: 1-844-307-0342, Relay 711. Further, the MCO's website was recently updated to include QAPI goals and objectives.	
Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance. The MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.	**Documents** Description of methods used to solicit feedback and recommendations Onsite discussion	Full	This requirement is addressed in the 2018 Member handbook. Under Quality Improvement Program (pages 58-59). During the onsite review, the MCO advised that members can provide information on the website or call in to member services.	
Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-	**Documents** QM Program Description	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17.	

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site operational review of the MCO and any additional QM reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.			As noted om the Program Description: QM coordinators are responsible for maintaining department documentation to support state contract requirements and NCQA standards. A QM Coordinator may specialize in one area of the quality process or may be cross-trained across several areas. QM Coordinators collaborate with other departments as needed to promote integration and implement corrective action or improvement initiatives as identified through QAPI activities and quality of care reviews.	
QAPIC The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes. The MCO must form a QAPIC no later than one month following the contract's start date. The MCO's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.	**Documents** QM Program Description Description of QAPIC	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 – pg. 12. During the onsite review, the MCO cited continual participation of providers in the QAPIC meetings and they have their first member commitment for the May 2018 meeting.	
The MCO must include, at a minimum, the following as members of the committee: 1. The MCO's QM Coordinator. 2. The MCO's Performance and Quality Improvement Coordinator. 3. The MCO's Medical Management Coordinator.	**Documents** QAPIC membership	Full	This requirement is addressed on the QAPI Committee Minutes. Evidence was provided in the sign-in sheets for the meetings held on 11/7/17 and 2/6/18. During the onsite review, the MCO stated that QAPI meetings are held in the evenings to encourage providers to attend at their convenience.	

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4. The MCO's Member Services Manager. 5. The MCO's Provider Services Manager. 6. Family members/guardians of children or youth who are Medicaid members. 7. Adult Medicaid members. 8. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.				
The MCO's QAPIC must: 1. Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC. 2. Review the Cultural Competency Plan. 3. Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify. 4. Establish annual performance targets. 5. Review and approve all member and provider surveys prior to their submission to MLTC.	**Documents** QM Program Description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 – pgs. 12 and 13, and policy NE.QI.26 - Cultural Competency. This requirement is addressed on the QAPI Committee Minutes and Agendas. Evidence was provided for the 11/7/17 and 2/6/18 meetings schedule during the review period. During the onsite review, the MCO advised that although attending QAPI meetings is built-in to the provider business agreement, they are also compensated for their time.	

Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6. Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries. 7. Provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization. 8. Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.				
Additional required committees must include: 1. Clinical Advisory Committee. 2. Corporate Compliance Committee. 3. Provider Advisory Committee. 4. Utilization Management Committee. 5. The additional required committees must report, on a minimum of a quarterly basis, to the QAPIC. The QAPIC must monitor performance as part of its annual QAPI Work Plan and Program Evaluation.	**Documents** Committee descriptions List of membership for each committee QM work plan QM Evaluation	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 – Committee Chart on pg. 11. The MCO also provided as evidence, the QM Work Plan Standards 2018, and the QI Evaluation 2017	

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Data Collection The MCO must collect performance data and conduct data analysis with the goal of improving members' quality of care. The MCO must document and report to the State its results on performance measures chosen by MLTC to improve quality of care and members' health outcomes.	**Reports** Reports of state-required performance measures	Full	This requirement is addressed in the HEDIS 2018 – 12-15-17 Excel file detailing each PM rate. The QI Work Plan addresses this requirement with monthly meetings to discuss the progress of the ongoing PIPs with MLTC.	
Data analysis must consider the MCO's previous year's performance, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO must ensure that data received from providers is accurate and complete by: 1. Verifying the accuracy and timeliness of reported data. 2. Screening the data for completeness, logicalness, and consistency. 3. Collecting service information using MLTC-developed templates. A quarterly report from the Quality Oversight Committee containing an activity summary as is due	**Documents** Process for verifying the accuracy and completeness of provider and vendor reported data Process for screening data for completeness, logic and consistency Evidence of collecting service utilization data using MLTC-developed templates **Reports** Sample data analysis produced by MCO providing information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17 – HEDIS Coordinator (page 22). The HEDIS Coordinator will report to the QM Director and be responsible for ensuring HEDIS data accuracy and timely reporting; tracking compliance with HEDIS measures and participating in related quality improvement initiatives. The HEDIS Coordinator also will maintain an overall action plan for improving performance on HEDIS measures. The MCO also provided the 2018 Q1 NTC Quality Oversight Committee Report, along with evidence of timely submission to MLTC.	

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to MLTC 45 calendar days following the most recent quarter				
The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCO.	**Documents** Evidence of timely and accurate reporting of encounter data to MLTC **Reports** Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up	Full	This requirement was addressed in the 2018 Q1 NTC Quality Oversight Committee Report. Additional evidence was provided in: QOC Report Q3 and Q4 2017; NE Encounter Performance Tracking 9-1-17 to 3-30-18 IPRO Audit; HEDIS RATES: N PROD NE HEDIS 2018 DEC2861_ALL_12152017; and HEDIS2019March18run.	
Quality Performance Measurement and Evaluation The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC. HEDIS results due date: June 30 CHIPRA quality measures and Adult core measures due date: 45 calendar days following 12th month of contract year	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final audit report and IDSS rates CAHPS report Onsite discussion	Full	NTC's PIP proposals were submitted in December 2017, in anticipation of the project start date of January 1, 2018. The annual reports associated with these PIPs (Tdap in pregnant women, 17p initiation, and follow-up after an ED visit for mental health/substance use disorder) will be expected within the 30 calendar days following the twelfth month of the contract year, per Attachment 38. The MCO provided reports of state-required performance measures: HEDIS RATES: N PROD NE HEDIS 2018 DEC2861_ALL_12152017 HEDIS2019March18run During the onsite review, the MCO noted that 2018 is the first year of their participation in HEDIS. The MCO will submit all necessary performance measures, per Attachment 7, by the appropriate due dates.	

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Attachment 7: Adult Core Measures 1. Cervical Cancer Screening (CCS) 2. Chlamydia Screening in Women (CHL) 3. Flu Vaccinations for Adults Age 18 and Older (FVA) 4. Screening for Clinical Depression and Follow-Up Plan (CDF) 5. Breast Cancer Screening (BCS) 6. Adult Body Mass Index Assessment (ABA) 7. PC-01: Elective Delivery (PC01) 8. PC-03: Antenatal Steroids (PC03) 9. Prenatal & Postpartum Care: Postpartum Care Rate (PPC) 10. Initiation and Engagement of Alcohol and Other 11. Drug Dependence Treatment (IET) 12. Medical Assistance with Smoking and Tobacco Use Cessation (MSC) 13. Antidepressant Medication Management (AMM) Follow-Up After Hospitalization for Mental Illness (FUH) 14. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA) 15. Controlling High Blood Pressure (CBP) 16. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C) 17. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)* 18. PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01) 19. PQI 08: Heart Failure Admission Rate (PQI08) 20. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05) 21. PQI 15: Asthma in Younger Adults Admission Rate (PQI15)			2017 CAHPS reports were submitted to meet this requirement, along with the CAHPS 2018 timeline.	

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22. Plan All-Cause Readmissions (PCR) 23. HIV Viral Load Suppression (HVL) 24. Annual Monitoring for Patients on Persistent Medications (MPM) 25. Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR) 26. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA) <u>Child Core Measures</u> 1. Child and Adolescents' Access to Primary Care Practitioners (CAP) 2. Chlamydia Screening in Women (CHL) 3. Childhood Immunization Status (CIS) 4. Well-Child Visits in the First 15 Months of Life (W15) 5. Immunizations for Adolescents (IMA) 6. Developmental Screening in the First Three Years of Life (DEV) 7. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) 8. Human Papillomavirus Vaccine for Female Adolescents (HPV) 9. Adolescent Well-Care Visit (AWC) 10. Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI) 11. PC-02: Cesarean Section (PC02) 12. Live Births Weighing Less Than 2,500 Grams (LBW) 13. Frequency of Ongoing Prenatal Care (FPC) 14. Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)				

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

Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9. Use of Appropriate Medications for People with Asthma 10. Annual Monitoring for Patients with Persistent Medications 11. Adults' Access to Preventative/Ambulatory Health Services 12. Antibiotic Utilization 13. Frequency of Ongoing Prenatal Care 14. Timeliness of Prenatal Care				
MLTC may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects will be based on HEDIS, external quality review (EQR), or other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC on request with its methodology for calculating performance measures.	**Reports** HEDIS final audit report and IDSS rates	Full	This requirement is addressed in policy/procedure CC.QI.21 Healthcare Effectiveness Data Information Set (HEDIS) and CC.QI.21.04 Supplemental Data Sources for HEDIS reporting. During the onsite review, the MCO noted that 2018 is the first year of their participation in HEDIS. The MCO will submit all necessary performance measures, per Attachment 7, by the appropriate due dates.	
The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.	**Reports** HEDIS final audit report and IDSS rates Trended performance measure results	Full	This requirement is addressed in policy/procedure CC.QI.21 Healthcare Effectiveness Data Information Set (HEDIS) and CC.QI.21.04 Supplemental Data Sources for HEDIS reporting. During the onsite review, the MCO noted that 2018 is the first year of their participation in HEDIS. The MCO will submit all necessary performance measures, per Attachment 7, by the appropriate due dates.	

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The MCO must report results of measuring or assessing outcomes and quality, and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the QAPI Committee and approved by MLTC.	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final IDSS rates Review of website Onsite discussion	Full	NTC provided reports for each of the PIPs that were submitted in December 2017 for the January 2018 implementation. These PIPs were selected based on state priorities, and areas where opportunities were identified. HEDIS FUM and FUA measures are being used to evaluate the behavioral health PIP (Follow-up after an ED Visit for mental health illness/substance use disorder. The PIPs are reported to and validated by IPRO annually, and discussed monthly at the Quality Improvement Committee meetings, and quarterly at the Quality Management Committee meetings with the other MCOs and MLTC.	
Any outcomes and performance measure results that are based on a sample of member, family, or provider populations must demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.	**Reports** HEDIS final audit report and IDSS rates Methodology for non-HEDIS performance measure reporting Trended performance measure results and comparison to national benchmarks including f/u actions taken	Full	This requirement is addressed in policy/procedure CC.QI.21 Healthcare Effectiveness Data Information Set (HEDIS) and CC.QI.21.04 Supplemental Data Sources for HEDIS reporting. During the onsite review, the MCO noted that 2018 is the first year of their participation in HEDIS. The MCO will submit all necessary performance measures, per Attachment 7, by the appropriate due dates.	
Performance Improvement Projects The MCO must conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIPs must meet all relevant CMS	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the following PIP submission documents: NTC 2018 17P PIP Proposal v3 NTC 2018 ED Follow Up PIP Proposal v2 NTC 2018 Tdap PIP Proposal v3	

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requirements and be approved by MLTC prior to implementation.			During the onsite review, the MCO noted positive experiences when collaborating with Nebraska MCOs on these projects.	
The MCO must participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC.	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the following PIP submission documents: NTC 2018 17P PIP Proposal v3 NTC 2018 ED Follow Up PIP Proposal v2 NTC 2018 Tdap PIP Proposal v3	
PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program Evaluation. PIPs must comply with CMS requirements, including: 1. A clear study topic and question as determined or approved by MLTC. 2. Clear, defined, and measurable goals and objectives that the MCO can achieve in each year of the project. 3. A study population. 4. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.	**Documents** QM Program Description QM work plan QM Evaluation	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17, the QM Workplan Standards 2018 – Final, QI Evaluation – 2017, and the NTC QI Program Evaluation 2017. IPRO will continue to monitor PIP activities, and validate meaningful data collection and intervention development in response to barriers, evaluation of intervention tracking measures, and potential for sustainability of the project.	

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5. The methodology for evaluation of findings from data collection. 6. Implementation of system interventions to achieve quality improvement. 7. A methodology for the evaluation of the effectiveness of the chosen interventions. 8. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable. 9. Planning and initiation of activities for increasing and sustaining improvement.				
The MCO must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.	**Documents** QM Program Description QM work plan QM Evaluation	Full	This requirement is addressed in the QAPI Program Description 2018 – Reviewed/Revised 11/09/17, the QM Workplan Standards 2018 – Final, QI Evaluation – 2017, and the NTC QI Program Evaluation 2017.	
Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program.	**Reports** PIP proposals and status reports	Full	This requirement is addressed in the following PIP submission documents: NTC 2018 17P PIP Proposal v3 NTC 2018 ED Follow Up PIP Proposal v2 NTC 2018 Tdap PIP Proposal v3	
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.	Onsite discussion	Not Applicable	During the onsite review, the MCO indicated that although no additional performance measures and PIPs were requested by CMS or other stakeholders, subcommittees were initiated for pharmacy/drug utilization and pregnant members.	

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Member Satisfaction Surveys The MCO must contract with a vendor that is certified by NCQA to perform CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items.	**Documents** Identity of CAHPS vendor **Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the 2017 CAHPS report (off cycle) for: 2017 Adult Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid w/CCC Off Cycle Summary Report with 2017 QC In addition, the MCO provided their CAHPS 2018 Timeline. During the onsite review, the MCO advised that in an effort to increase their CAHPS rates, they joined the national program 'Ask Me 3'. This program helps aid members and encourages them to ask their physicians three specific questions to better understand their health conditions and what they need to do to stay healthy. Although outside this review period, the MCO's website was updated to include the 'Ask Me 3' program.	
The MCO must use the most current version of CAHPS for Medicaid enrollees. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports to MLTC to fulfill the CHIPRA requirement.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the 2017 CAHPS report (off cycle) for: 2017 Adult Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid w/CCC Off Cycle Summary Report with 2017 QC In addition, the MCO provided their CAHPS 2018 Timeline.	

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Samples of members 18 years of age and older and caregivers/family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers/family members based on the type of question asked.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the 2017 CAHPS report (off cycle) for: 2017 Adult Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid w/CCC Off Cycle Summary Report with 2017 QC In addition, the MCO provided their CAHPS 2018 Timeline.	
Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. MLTC reserves the right to make CAHPS member survey results public.	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the 2017 CAHPS report (off cycle) for: 2017 Adult Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid w/CCC Off Cycle Summary Report with 2017 QC In addition, the MCO provided their CAHPS 2018 Timeline.	
Survey results and descriptions of the survey process must be reported to MLTC separately for each required CAHPS survey. Upon administration of the CAHPS Child surveys, results for Medicaid children and CHIP children must be reported separately. CAHPS reports due date: 30 calendar days following 12th month of contract year	**Reports** CAHPS adult and child survey reports Onsite discussion	Full	This requirement is addressed in the 2017 CAHPS report (off cycle) for: 2017 Adult Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid Off Cycle Summary Report with 2017 QC 2017 Child Medicaid w/CCC Off Cycle Summary Report with 2017 QC In addition, the MCO provided their CAHPS 2018 Timeline.	

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Provider Satisfaction Surveys The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes, including medical reviews and support for PCMH implementation.	**Documents** Provider satisfaction survey tool Onsite discussion	Full	This requirement is addressed in the NTC 2017 Provider Satisfaction final report – pgs. 56-57. Nebraska Total Care, 2017 Provider Satisfaction Final Report: from the sample of 1,500, a total of 303 surveys were completed (114 mail, 37 Internet, and 152 phone), yielding a response rate of 11.1% for the mail/Internet data component and 20.5% for the phone data component. Overall provider satisfaction with NTC was 37.2%. This rate is below the Medicaid 10th percentile. During the onsite review, the MCO attributed the low provider satisfaction rate to the "learning curve" required to bring the Customer Service staff up to date on the new NTC system.	
The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.	**Documents** Provider satisfaction survey tool and methodology Onsite discussion	Full	This requirement is addressed in the NTC 2017 Provider Satisfaction final report (pages 56-57).	
The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods	**Reports**	Full	This requirement is addressed in the NTC 2017 Provider Satisfaction final report (pages 56-57).	

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and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. Provider satisfaction survey report due date: 30 calendar days following 12th month of contract year	Provider satisfaction survey results including f/u actions taken		The MCO provided evidence of timely submission to MLTC.	
Member Advisory Committee To promote a collaborative effort to enhance the MCO's patient-centered service delivery system, the MCO must establish a Member Advisory Committee that is accountable to the MCO's governing body. Its purpose is to provide input and advice regarding the MCO's program and policies.	**Documents** Member Advisory Committee description	Full	This requirement is addressed in the NTC Member Advisory Committee Charter.	
The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.	**Documents** Member Advisory Committee description Member Advisory Committee membership	Full	This requirement is addressed in the NTC Member Advisory Committee Charter. Membership indicated on the minutes for 10/25/17 and 1/25/18. During the onsite review, the MCO advised eight members attended in person or on phone in October 2018. However, only one member attended in January 2018.	
At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QM/quality improvement activities; program monitoring and evaluation; and, member, family, and provider education.	**Documents** Member Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC Member Advisory Committee Charter. Topics discuss on the agenda and minutes for 10/25/17 and 1/25/18.	
The MCO must provide an orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and	**Documents** Evidence of orientation and training including training materials	Full	This requirement is addressed in the NTC_MAC (PowerPoint) training presentation.	

Quality Management				
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understanding of the managed care program to fulfill their responsibilities.			During the onsite review, the MCO noted members have not changed and they were trained in March 2017. The MCO advised they are looking to initiate an informational pamphlet to reinforce their members' understanding of the managed care program at the start of each meeting.	
The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This Plan must be submitted to MLTC for approval a minimum of 60 calendar days before the contract start date and annually thereafter.	**Documents** Member Advisory Committee Plan	Full	This requirement is addressed in the NTC Member Advisory Committee Charter. Topics discussed were documented on the agenda and minutes for 10/25/17 and 1/25/18. Copay issues discussed during the 10/25/17 meeting were clarified during the 1/25/18 meeting. The MCO advised the language in the Member Handbook and on the website was strengthened to reflect this. Members are able to show this documentation to providers to confirm the absence of co-pays if necessary. The MCO provided evidence of timely submission to MLTC.	
The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC Member Advisory Committee Charter. Topics discussed were documented on the agenda and minutes for 10/25/17 and 1/25/18.	
The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members,	**Documents** Semi-annual reports submitted during the review period	Substantial	Prior Results (2017) Substantial- NTC submitted their MAC report on time to MLTC. Member addresses were not indicated within this report. The report indicates that the transition to three MCOs has been difficult for behavioral health providers.	

Quality Management				
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and information about Committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in Attachment 38 – Revised Reporting Requirements. Semi-annual reports due date: June 30 and Dec 31			Complications could lead to providers making the decision to not accept Medicaid members and cause limited access. Provider concerns are ongoing and being addressed by NTC Provider Relations. MCO Response NTC agrees with the findings and have added the member addresses to the meeting attendance and will supply with the report. This requirement is addressed in the MAC MLTC Report 12312017. However; name, address and organization represented were not evident in this report, and not included in the 10/25/17 report or the 1/25/18 MAC minutes. The MCO provided evidence of timely submission to MLTC. **Recommendation** The MCO should include the name, address and organization represented for each member on the committee. **MCO Response** NTC agrees with findings. **IPRO Final Findings** No change in review determination.	
Clinical Advisory Committee The MCO must develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including	**Documents** Clinical Advisory Committee description Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC CAC Agenda 11_21_2017 (changed to 121417) NTC CAC MEETING MINUTES 12142017 APPROVED NTC CAC Agenda 01_16_2018	

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diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or substance use disorder treatment for adults, children, and adolescents in the State.			NTC CAC MEETING MINUTES 011618 NTC Clinical Advisory Committee Charter	
The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice guidelines, and utilization management criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC CAC Agenda 11_21_2017 (changed to 121417) NTC CAC MEETING MINUTES 12142017 APPROVED NTC CAC Agenda 01_16_2018 NTC CAC MEETING MINUTES 011618	
The committee must include members who care for children, adolescents and adults in the State across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations and represent pharmacists, physical health providers, and behavioral health providers.	**Documents** Clinical Advisory Committee membership	Full	This requirement is addressed in the CAC meeting minutes.	
The committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed/approved by the Committee prior to adoption by the MCO.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC CAC Agenda 11_21_2017 (changed to 121417) NTC CAC MEETING MINUTES 12142017 APPROVED NTC CAC Agenda 01_16_2018 NTC CAC MEETING MINUTES 011618	
The committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.	**Documents** Agendas and meeting minutes for all committee meetings held during review period	Full	This requirement is addressed in the NTC CAC Agenda 11_21_2017 (changed to 121417) NTC CAC MEETING MINUTES 12142017 APPROVED NTC CAC Agenda 01_16_2018 NTC CAC MEETING MINUTES 011618	

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External Quality Review The MCO is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR 438.350. The EQR is conducted by MLTC's contracted external quality review organization (EQRO) or other designee. The EQR will include, but is not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.	Onsite discussion	Full	This requirement was addressed during the onsite audit held at WellCare in Omaha, Nebraska on May 16, 2018 – May 17, 2018.	
The MCO must provide the necessary information required for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.	Onsite discussion	Full	This requirement was addressed during the onsite audit held at WellCare in Omaha, Nebraska on May 16, 2018 – May 17, 2018.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Utilization Management **General Requirements** The MCO's UM activities must include the evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them. The MCO's UM program must also focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services.				
The MCO must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in UM Program Description NE.UM.01 on pages 9-10.	
UM Program Description The MCO must have a written UM Program description that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum: Criteria and procedures for the evaluation of medical necessity of medical services for members.	**Documents** UM Program Description should address all sub-elements	Full	This requirement is addressed in UM Program Description NE.UM.01 on page 14. The MCO provided verification that files we uploaded to MLTC.	
Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.		Full	This requirement is addressed in UM Program Description NE.UM.01 on pages 19 and 25.	
Mechanisms to detect and document over- and under-utilization of medical services.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 4.	

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Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 4.	
Availability of UM criteria to providers.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 18.	
Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 17.	
Availability of physician reviewers to discuss determinations by telephone with physicians who request them.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 25.	
Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 17.	
A process and procedures to address disparities in health care.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 7.	
A process for identifying and analyzing clinical issues by appropriate clinicians and, when necessary, developing corrective actions to improve services.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 7-8.	
A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 19-23.	
Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List and other State publications.		Full	This requirement is covered in UM Program Description NE.UM.01 on page 11.	
A process for providing prescribers with members' drug utilization data obtained from MLTC and the		Full	This requirement is addressed in : NE.PHAR.07 Drug Utilization Review Program	

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Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must: 1. Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing. 2. Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.			EPS.PHAR.05 Drug Utilization Review	
A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 30 calendar days after its completion.		Full	This requirement is addressed in UM Program Description NE.UM.01 on page 33. The MCO provided their Quality Assessment and Performance Improvement Program Evaluation 2017 which includes a full evaluation of the UM Program.	
Practice Guidelines The MCO must develop practice guidelines that: Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	**Documents** Policy/procedure List of practice guidelines developed/adopted by MCO Examples of practice guidelines	Full	This requirement is addressed in UM Program Description NE.UM.01 on page 18. This is further developed in Policy NE.UM.02 - Clinical Decision Criteria and Application. The MCO also provided a link to Provider section of their website that includes practice guidelines.	
Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in UM Policy NE.UM.02.04 - Special Health Care Needs (SHCN). The minutes from UM committee meeting on 10/25/17 contain the following:	

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			NE.CM.02 Care Coordination/Case Management (annual review- no updates) Purpose- to provide guidelines for identification of members that have the greatest need for, and can most benefit from, care coordination/management, including complex care management. NE.CM.02.24 Special Health Care Needs (annual review- no updates) Purpose- to ensure that individuals with Special Health Care Needs are in receipt of medically necessary services. Plan will collaborate and coordinate to ensure timely and cost effective approach to care.	
Are adopted in consultation with participating health care professionals.	**Documents** Policy/procedure Evidence of participation of health care professionals	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 8. UM committee minutes indicate participation of providers and consultation on policies and guidelines.	
Are reviewed and updated a minimum of annually, as appropriate.	**Documents** Policy/procedure	Full	This requirement is addressed in the UM Program Description NE.UM.01 on pages 1 and 17.	
Are disseminated, by the MCO, to all affected providers and, on request, to members and enrollees.	**Documents** Policy/procedure Evidence of dissemination to providers Member Handbook	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 18. Distribution to members is addressed in Policy NE.QI.08 on page 3.	
Are posted to the MCO's website.	**Documents** Policy/procedure	Full	Distribution to members is addressed in Policy NE.QI.08 on page 3.	

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	View website onsite		These are available on the Provider Portal and MCO language information is also available on the member website.	
Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply.	**Documents** Policy/procedure	Full	This requirement is addressed in the UM Program Description NE.UM.01.	
The MCO must provide affected network providers with technical assistance and other resources to implement the practice guidelines.	**Documents** Policy/procedure Evidence of offering/providing technical assistance and other resources	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 4. The provider portal contains training programs, the Practice Improvement Resource Center, and provider newsletters with useful technical support.	
The MCO must monitor the application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 34. Page 6 of Policy NE. QI. 01 specifically mentions peer review of health care practices. The MCO provided minutes of the Performance Improvement Committee which includes a review of HEDIS and CAHPS among other topics.	
Using information acquired through its QM and UM activities, the MCO must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and UR activities.	**Documents** Policies/procedures **Reports** Most recent written recommendations and evidence of transmittal to MLTC	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 33. Recommendations are made to the QAPI and up to the MCO Board of Directors. These are transmitted to MLTC within the broader Quality Management report.	

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Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Service Authorization Procedures The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services	**Documents** Policies/procedures addressing all sub-elements	Full	This requirement is addressed in policy CC.UM.06.01 - Initiation of Authorization Request.	
The MCO must: 1. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into MCO documents, where applicable.		Full	This requirement is addressed in policy NE.UM.02- Clinical Decision Criteria and Application	
2. Not require service authorization for emergency services.		Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 19.	
3. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.		Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 15.	
4. Not arbitrarily deny a required service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors.		Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 15.	
5. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.	**Reports** Also includes evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the UM Program Description NE.UM.01. NTC Provided IRR testing results for Prior Authorization and Concurrent Review as well as audit tools for UM staff management.	

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Utilization Management				
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6. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.		Full	This requirement is covered in EPS.PHARM.05 - Drug Utilization Review Policy. The PDL and prior authorization forms are available on the provider website.	
7. Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth.		Full	This requirement is addressed in NE.PHAR.10 - Psychotropic Drug Oversight.	
8. Have written policies and procedures for prescribers to request peer review and peer-to-peer consultations on prior authorizations. Peer-to-peer review or peer consultation must be conducted by a State-licensed prescriber.		Full	This requirement is addressed in NE.UM.07- Adverse Determination (Denial) Notices and in NE.PHAR.100 - Pharmacy Prior Authorization and Medical Necessity Criteria.	
9. Consult with the requesting network provider, when appropriate.	**Onsite File Review**	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 25. File Review Results Ten (10) of 10 files met this requirement.	
Concurrent Review The MCO must develop a system of concurrent review for inpatient services to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.	**Documents** Policy/procedure	Full	This requirement is addressed in the UM Program Description NE.UM.01 and in NE.UM.01.07 - Concurrent Review on page 1.	
An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical guidelines. The MCO must use published and commercially available criteria for hospital case reviews to facilitate evaluation by UR nurses.	**Documents** Policy/procedure Identification of criteria used	Full	This requirement is covered in NE.UM.01.07 - Concurrent Review page 4. InterQual as national benchmark	

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Retrospective Utilization Review of Network Providers The MCO must develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including: 1. A system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 8. NTC also provided their Clinical Initiatives Dashboard, ER visits report, Prelim and FFP by NPI, PD report for Q1 2018, and an example of an outlier query that led to further investigation. Upon discussion onsite, the MCO stated that special needs are identified and assessed through a software tool called Impact Pro. They look at high utilization for identifying targets for case management – they also look at an engagement score (likelihood to engage). Additional tools from corporate are used, such as in reviewing the schizophrenic population. There is a cross-over to behavioral health.	
2. A reasonable appeal process that includes: standard communication with reasonable timelines, UR criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims.	**Documents** Policy/procedure	Full	This requirement is addressed in the UM Program Description NE.UM.01 on page 25.	
3. Written policies and procedures through which the prescriber of pharmacy services is able to submit additional information for special consideration and additional review of denied prior authorization requests that do not meet criteria.	**Documents** Policy/procedure	Full	This requirement is addressed in NE.PHAR.100 - Pharmacy Prior Authorization and Medical Necessity Criteria.	
4. Retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary,	**Documents** Policy/procedure **Reports**	Full	This requirement is addressed in CC.COMP.16 - Fraud, Waste and Abuse Plan and CC.COMP.16.01 - EOB Service Verification.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
and were authorized and billed in accordance with the MCO's requirements.	Evidence of retrospective and peer reviews including results and f/u actions taken		NTC also provided an outlier report.	
5. Provider reviews related to Medicaid compliance issues.	**Documents** Policy/procedure Example of a provider review related to compliance	Full	This requirement is addressed in CC.COMP.16 - Fraud, Waste and Abuse Plan.	
6. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.	**Documents** Policy/procedure	Full	This requirement is addressed in CC.COMP.16 - Fraud, Waste and Abuse Plan.	
7. Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under-and over- utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Substantial	Prior Results (2017) Substantial- This requirement is addressed in NTC's UM Program Description (pages 7-8) and in policy and procedure NE.UM.01.03 Monitoring Utilization (which includes reference to race, ethnicity, gender and age). Drug/age contraindication was reviewed, per report NE_US_MD_Drug_Utilization_Review_(RA5100). No report was submitted that evaluated demographic factors such as race, ethnicity and gender. MCO Response NTC Agrees with the findings. NTC is developing a report for under and over utilization (including data elements of the gender/ race/ ethnicity/ and age) with data analytics. This requirement is addressed in the UM Program Description NE.UM.01 on pages 7-8 'disparities in health care' and on page 4 – 'guard against over and under-utilization of	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			services and interactive relationships with practitioners to promote appropriate practice standards'. A policy reading provided no finding of the wording changes to incorporate race/ ethnicity as per MCO response from last year's findings. Version of policy was revised 1/12/18. MCO did not submit NE.UM.01.03 this year so it was not reviewed. The MCO provided report – IMPACT ORCA risk scores. This utilization report contains data elements gender, age, race ethnicity and language spoken. **Recommendation** The MCO should add the wording from the State Contract related to monitoring providers' utilization of services by race, ethnicity, gender, and age. **MCO Response** NTC agrees with the findings. As indicated, Policy NE.UM.01.03 was revised to reflect the language: Monitoring includes services at all levels of care, and utilization of services by race, ethnicity, gender, and age. This policy will be submitted upon next IPRO review. **IPRO Final Findings** No change in review determination.	
The MCO must monitor for potential off-label drug usage.	**Documents** Policy/procedure	Full	Prior Results (2017)	

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	Reports Evidence of monitoring including results and f/u actions taken		Substantial- NTC did not submit any reports that evaluated for off-label drug usage, specifically, however they submitted two policies (NE PHAR 13 and CP.PMN.53), each of which contain a description of the procedures for evaluating the need for this usage among their membership. MCO Response NTC Agrees with findings. NTC is working on a report specific to off-label drug use and will be reporting out to appropriate quality committees within NTC. This requirement is addressed in policy CP.PMN.53 - No Coverage Criteria/Off-Label Use Policy. NTC provided the Off Label Denial Report in follow-up to last year's compliance review findings.	
The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization. For UR, the test for appropriateness of the request for emergency services must be whether a prudent layperson would have requested such services. A prudent layperson is one who possesses an average knowledge of health and medicine.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	Prior Results (2017) Substantial- This requirement is addressed in policy CC.CM.05 ED Diversion. A report demonstrating that emergency service utilization is being monitored by provider and member should be provided for the 2018 compliance audit. MCO Response NTC is developing a utilization report of ED visits specific to provider and member. This requirement is addressed in the UM Program Description NE.UM.01 on page 28.	

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			The MCO provided an ED Utilization Report as evidence of monitoring.	
Utilization Management Committee The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-chaired by the Medical Director and must report its findings to the QAPIC. The UM Committee must review, at a minimum: 1. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan. 2. Grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes. 3. Information from UM operations relevant to system gaps are identified and shared with provider network staff through this committee. 4. Results from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities.	**Documents** UM Committee description List of membership Agendas and meeting minutes for all committee meetings held during review period **Reports** UM reports for review period UM Program Evaluation	Full	This requirement is addressed in the UM Program Description NE.UM.01 on pages 7-9 and the NTC UM Committee Charter 2016. The MCP also provided committee minutes for Q4 2017 and Q1 2018.	

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Service Authorizations and Notices of Action **Service Authorization** The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in Policy NE.UM.05 - Timeliness of UM Decisions and Notifications.	
The MCO must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results Ten (10) of 10 files met this requirement.	
Notice of Adverse Action The MCO must notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	**Documents** Policy/procedure Template notice of action	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1.	
The MCO must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:	**Documents** Policy/procedure	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1.	
1. The action the MCO or its subcontractor has taken or intends to take.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results Ten (10) of 10 files met this requirement.	
2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Ten (10) of 10 files met this requirement.	
3. The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results Ten (10) of 10 files met this requirement.	
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is covered in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results Ten (10) of 10 files met this requirement.	
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is covered in Policy NE.UM.07 Adverse Determination Denial Notices on page 4. File Review Results Ten (10) of 10 files met this requirement.	
6. Procedures for exercising a member's rights to appeal or grieve a decision.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 2. File Review Results Ten (10) of 10 files met this requirement.	
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 1. File Review Results Ten (10) of 10 files met this requirement	

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Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8. The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 4. File Review Results Ten (10) of 10 files met this requirement	
The notice must be in writing and must meet the language and format requirements. The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency. The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish.	**Documents** Policy/procedure **Onsite File Review**	Full	This requirement is addressed in Policy NE.UM.07 Adverse Determination Denial Notices on page 4 and in NE.MBRS.02 - Member Materials Readability and Translation. File Review Results Ten (10) of 10 files met this requirement.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.				
Timeframes for Notice of Action The MCO must provide notice to the member a minimum of ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified. The MCO must give notice by the date of the action under the following circumstances: 1. The death of a member. 2. A signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services. 3. The member's admission to an institution where he or she is ineligible for further services. 4. The member's address is unknown and mail directed to him/her has no forwarding address.	**Documents** Policy/procedure	Full	This requirement is addressed in Policy NE.UM.05 - Timeliness of UM Decisions and Notifications.	

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Utilization Management				
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5. The member has been accepted for Medicaid services by another state. 6. The member's physician prescribes the change in the level of medical care. 7. An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989. 8. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 calendar days (applies only to adverse actions for nursing facility transfers).				
The MCO must provide notice on the date of action when the action is a denial of payment.	**Documents** Policy/procedure	Full	This requirement is addressed in Policy NE.UM.05 - Timeliness of UM Decisions and Notifications.	
Standard Service Authorization Denial The MCO must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed 14 calendar days following receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an	**Documents** Policy/procedure **Onsite File Review**	Substantial	This requirement is addressed in Policy NE.UM.05 - Timeliness of UM Decisions and Notifications, NE.UM.07 - Adverse Determination (Denial) Notices and NE.UM.08 - Appeal of UM Decisions. File Review Results Nine (9) of 10 files met this requirement. Case #4 had notice sent in 15 days. **Recommendation** The MCO can improve its internal controls such that timeliness standards are met.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
appeal if he or she disagrees with that decision. The MCO must issue and carry out its determination as expeditiously as the member's health condition requires and in any event no later than the date the extension expires.			**MCO Response** MCO agrees with findings and has improved internal controls to assure compliance with timeliness. **IPRO Final Findings** No change in review determination.	
Expedited Service Authorization Denial For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in Policy NE.UM.08 - Appeal of UM Decisions.	
Untimely Service Authorization Decisions The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.	**Documents** Policy/Procedure	Full	This requirement is addressed in Policy NE.UM.05 - Timeliness of UM Decisions and Notifications.	

IPRO
Improving Healthcare for the Common Good

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Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
Grievance and Appeals **General Requirements** The MCO must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The MCO must distinguish between a grievance, grievance system, and grievance process, as defined below: 1. A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions. 2. The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process. 3. A grievance process is the procedure for addressing members' grievances.	**Documents** Policy/procedure UM Program Description in place during the review period	Full	This requirement is addressed in the policy/procedure document provided: NE.QI.11, page 1, Section B-1, and Purpose statement.	
The MCO must: 1. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in the policy/procedure NE.QI.11 page 3, section A-2.	
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template acknowledgement notice **Onsite File Review**	Substantial	This requirement is addressed in the policy/procedure NE.QI.11 page 3, section A-5. File Review Results	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Grievance and appeal file review results		Ten (10) out of 10 appeals files contained evidence of a timely acknowledgement letter. Sixteen (16) of 20 grievance files contained evidence of a timely acknowledgement letter; the remaining 4 grievance files contained acknowledgement letters that were dated past 10 calendar days after the request was received. **Recommendation** The MCO should ensure timely acknowledgment letters are provided for all members who file a grievance or appeal. **MCO Response** NTC agrees with findings. **IPRO Final Findings** No change in review determination.	
3. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: a. The denial of service is based on lack of medical necessity. b. Because of the member's medical condition, the grievance requires expedited resolution.	**Documents** Policy/procedure **Onsite File Review** Grievance and appeal file review results	Full	Prior Results (2017) Substantial-5 out of 10 appeal files contained the required information. 4 appeal files did not meet the requirement because the individual who did the review could not be determined. The remaining 1 appeal file was deemed not applicable because the appeal could not be processed (member did not submit the additional information requested by the MCO). MCO Response NTC agrees that we did not provide the internal clinical documentation that demonstrated separate reviewers. Staff is aware of the requirement and we do have this documentation in our internal systems as it is	

Grievances and Appeals				
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
c. The grievance or appeal involves clinical issues.			part of our daily workflow and will provide the completed document next audit. This requirement is addressed in policy/procedure NE.QI.11 page 2, sections A-6, A-7, and B-4. File Review Results Ten (10) out of 10 appeals files contained the required information. This requirement was not applicable for the 20 grievance files reviewed, since none related to a medical issue and were all first level reviews.	
4. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11 page 4, section A-9. File Review Results Ten (10) out of 10 appeals files met this requirement.	
Complaint and Grievance Processes A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in policy/procedure NE.QI.11, page 3, sections A 1 and 2; page 10, section H-1; Member Handbook page 62, 63; and Provider Manual, page 81.	
A member may file a grievance with the MCO or the State at any time.	**Documents** Policy/procedure Member Handbook	Minimal	There was no language found in the documentation provided that states "A member can file a grievance with the MCO or State at any time." Onsite, the MCO stated additional documentation would be provided which contains this language, however no such documentation has been provided. There was	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			discussion about adding this verbiage to the website and policy going forward. **Recommendation** The MCO should add this language to their Member Handbook, all applicable policies and to their website. **MCO Response** NTC agrees with findings. NTC has added the wording "anytime" to all documentation including member handbook, provider manual, website and policy. **IPRO Final Findings** No change in review determination.	
The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the MCO receives the grievance.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Grievance file review results	Full	This requirement is addressed in policy/procedure NE.QI.11 page 5, section B-3 and in the member handbook, page 63. File Review Results Twenty (20) out of 20 grievance files demonstrated timely notice.	
MLTC will establish the method the MCO must use to notify a member of the disposition of a grievance.	**Documents** Policy/procedure Template grievance resolution notice **Onsite File Review** Grievance file review results	Full	This requirement is addressed in policy/procedure NE.QI.11 page 5, section B-3. File Review Results Twenty (20) of 20 grievance files demonstrated an appropriate method by which the MCO notified members of the disposition of a grievance.	
Appeal Processes	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11 page 6, section C-1;	

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A member may file a MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.	Member Handbook Provider Manual		policy and procedure NE.UM.08, policy statement; and provider manual page 81.	
Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO..	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in policy and procedure NE.QI.11, page 6, section C-2; policy and procedure NE.UM.08, page 3, section I-B; member handbook page 63; provider manual page 83; and NTC Webpage—Member.	
The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in policy/procedure NE.QI.11 page 6, section C-1; policy/procedure NE.UM.08 pages 2-3, sections I-A and I-D; and member handbook page 64.	
The MCO must: 1. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Substantial-9 out of 10 appeals case files were deemed not applicable because they contained inquiries in writing. The remaining 1 appeal file did not meet the requirement because there was no evidence of the inquiry for the appeal in the file. MCO Response The case in question (#9 case listing) originally was requested as an expedited appeal (verbally). The case was ultimately withdrawn by the provider. The review of the case determined it did not meet clinical definition of an expedited appeal, therefore NTC transferred the case to a standard appeal. An acknowledgement letter was sent within one business day. The provider withdrew the appeal request. IPRO Response Case listings #1-#6 and #9-#12 were reviewed (the appeal request was withdrawn for files #7	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			and #8, and thus the cases in the oversample were reviewed). File #12 was the case in which there did not appear to be evidence of the appeal request in the file. This requirement is addressed in policy/procedure NE.QI.11 page 6, section C-1; and policy/procedure NE.UM.08, page 3, sections I-A and I-E. File Review Results This requirement was not applicable for 10 out of 10 appeals files, as all inquiries were made in writing.	
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member Handbook Provider Manual	Substantial	There is no language in the grievance policy/procedure, Member Handbook, or Provider Manual which implies MCO must "Ensure that there is only one level of appeal for members" in the documentation provided. Onsite, the MCO stated that this language would be added to the applicable policies, as well as the Provider Manual and website. Given that the appeal process is explained to the member in a way which indicates only one level of appeal (i.e. the next step in the appeals process is a state fair hearing), it is implied that there is only one level of appeal for members. **Recommendation** The MCO should include the verbiage that there is only one level of appeal for members in the applicable policies, Provider Manual, and Member Handbook.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			MCO Response NTC agrees with findings. NTC has added the wording of "One level of appeal" to all documentation including Member Handbook, Provider Manual, website and policy. **IPRO Final Findings** No change in review determination.	
3. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	Prior Results (2017) Minimal-10 out of 10 appeal files did not have language specifically stating that members could present evidence in person. MCO Response NTC notes that we do have language in our acknowledgement letter stating "Tell us if you want to appeal in person. We will set a meeting place that is close to your home." First paragraph, last sentence. This is evidence in Case #1, Case #2, Case #5, Case #6, Case #10, Case #11. 6 of the 10 were compliant with this requirement. NTC reviewed all cases and determined that the when an appeal request is missing information, the letter requesting this additional information needed this additional sentence. Corrections have been made. This requirement is addressed in policy/procedure NE.QI.11 page 7, section C-5; and policy/procedure NE.UM.08 pages 1-2, policy statement. File Review Results	

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			Ten (10) out of 10 appeals files met this requirement.	
4. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11 page 7, section C-6; policy/procedure NE.UM.08 page 4, section II-A; and member handbook, page 64. File Review Results Ten (10) out of 10 appeals files met this requirement.	
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11 page 7, section C-7; and policy/procedure NE.UM.08 page 1, policy statement.	
The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must: 1. Make reasonable efforts to give the member prompt verbal notice of the delay. 2. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11 pages 7 and 8, sections C-8-10; and policy/procedure NE.UM.08 pages 6-7 sections V-D and page 2, policy statement. File Review Results Ten (10) out of 10 appeal files demonstrated evidence that the appeal was resolved within 30 days. There were no files in the sample that represented an extension.	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.				
The MCO must provide written notice of disposition, which must include: 1. The results and date of the appeal resolution; and 2. For decisions not wholly in the member's favor: a. The right to request a state fair hearing. b. How to request a state fair hearing. c. The right to continue to receive benefits pending a hearing. d. How to request the continuation of benefits. e. If the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.	**Documents** Policy/procedure Template appeal resolution notice **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section C-11; policy/procedure NE.UM.08, page 7, section E; and the 2018 appeal resolution notice template. File Review Results Ten (10) out of 10 appeals files contained the results and date of appeal resolution. Six (6) out of 10 appeals files contained the required information regarding decisions not wholly in the member's favor (4 files were not applicable, as the appeal was overturned).	
Expedited Appeals Process The MCO must establish and maintain an expedited review process for appeals that the MCO determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.UM.08, page 6, section V-B.	
The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.	**Documents** Policy/procedure Member Handbook Provider Manual	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-1; policy/procedure NE.UM.08, page 6, section V-B and page 3, section I-C; member handbook page 65; and provider manual page 84.	

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The MCO must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.	**Documents** Policy/procedure Member Handbook Template notice of action **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-2; policy/procedure NE.UM.08, pages 1-2, policy statement; and the 2018 template for a standard appeal acknowledgement. File Review Results One (1) out of 10 appeals files contained the required information. Nine (9) out of 10 appeals files were not applicable, as they were not expedited appeals.	
The MCO must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than 72 hours after the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-3; and policy/procedure NE.UM.08, pages 8-9, sections V-B, D, and pages 2-3, policy statement. File Review Results One (1) out of 10 appeals files contained the required information. Nine (9) out of 10 appeals files were not applicable, as they were not expedited appeals.	
For any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-4; and policy/procedure NE.UM.08, page 9, section V-D. File Review Results This requirement is not applicable for 10 of 10 appeals files, as an extension was not requested.	

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In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Substantial	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-5; and policy/procedure NE.UM.08, page 3, policy statement. File Review Results Nine (9) of out 10 appeals files were not applicable, as they were not expedited appeals. The one (1) applicable file reviewed did not contain evidence that the MCO provided the member with verbal notice of resolution. **Recommendation** Verbal notice of resolution of expedited appeals should be provided. Further, this verbal notice should be documented in the case notes for each expedited appeal. **MCO Response** NTC agrees with findings. Computer documentation has a required field for verbal notification. Monitoring/ audits performed to ensure compliance. **IPRO Final Findings** No change in review determination.	
The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-6; policy/procedure NE.UM.08, page 1, policy statement; and provider handbook, page 84 expedited appeals section.	
If the MCO denies a request for expedited resolution of an appeal, it must:	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 8, section D-7,	

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
1. Transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days. 2. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.			a and b; and policy/procedure NE.UM.08, page 6, section V-C and page 3, policy statement.	
Continuation of Benefits The MCO must continue a member's benefits if any one of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Ten (10) calendar days after the MCO mailing the Notice of Action; or b. The intended effective date of the MCO's proposed action. 2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. 3. The services were ordered by an authorized provider. 4. The authorization period has not expired. 5. The member requests an extension of benefits.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 9, section F-1; and policy/procedure NE.UM.08, pages 4-5, section III-A.	
If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:	**Documents** Policy/procedure	Full	This requirement is addressed by policy/procedure NE.QI.11, pages 9-10, section	

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6. The member withdraws the appeal or request for state fair hearing. 7. The member does not request an appeal within ten (10) calendar days from when the MCO mails an adverse resolution to the member's appeal. 8. A state fair hearing decision adverse to the member is made. 9. The authorization expires or authorization service limits are met.			F-2; and policy/procedure NE.UM.08, page 5, section III-B.	
The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 10, section F-3; and policy/procedure NE.UM.08, page 5, section III-B.	
Access to State Fair Hearings A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a state fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.	**Documents** Policy/procedure Member Handbook Provider Manual Template appeal resolution notice-upheld decision	Full	This requirement is addressed in policy/procedure NE.QI.11, page 9, section E-1; policy/procedure NE.UM.08, page 9, section VI; member handbook pages 62-65; provider manual page 84; and the 2018 appeal resolution/final adverse determination template.	
If the MCO takes action and the member requests a state fair hearing, the State must grant the member a state fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the MCO.	**Documents** Policy/procedure	Full	This requirement is addressed by policy/procedure NE.QI.11, page 9; member handbook page 66; member website—State Fair Hearing screenshot; and Final Adverse Determination 2018 NE Letter.	

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The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.	**Documents** Policy/procedure Template appeal resolution notice-upheld decision	Full	This requirement is addressed by policy/procedure NE.QI.11, page 9, section E-1,3; Final Adverse Determination 2018 NE Letter; and Member Website—State Fair Hearing screenshot.	
The parties to the State fair hearing include the MCO, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 9, section E-2; and policy/procedure NE.UM.08, page 9, section VI.	
Reversed Appeals If the MCO or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than 72 hours from the date the MCO receives notice reversing the determination.	**Documents** Policy/procedure	Full	This requirement is addressed by policy/procedure NE.QI.11, page 10, section F-5; and policy/procedure NE.UM.08, page 9, section VII.	
The MCO must pay for disputed services if the MCO or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 10, section F-4; and policy/procedure NE.UM.08, page 10, section VII.	

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Grievance and Appeal Recordkeeping Requirements The MCO must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date the grievance or appeal was received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance process, as applicable. e. Date of resolution at each level of the appeal or grievance process, as applicable. f. Name of the covered person by or for whom the appeal or grievance was filed. The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.	**Documents** Policy/procedure	Full	This requirement is addressed in policy/procedure NE.QI.11, page 4, section A-11; and policy/procedure NE.UM.08, page 10, section VIII.	
Information to Providers and Subcontractors The MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract: a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing. b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.	**Documents** Provider Manual Template provider contract Template subcontractor agreement	Full	This requirement is addressed in the 2017 Provider Manual, pages 81-84; page 2 of the NTC Provider-Subcontractor contract template, paragraph 1.16; and on page 4 of the NTC Provider-Subcontractor contract template, paragraph 2.4	

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c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings. d. The toll-free number(s) to use to file verbal grievances and appeals. e. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending. f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.				
Reporting of Complaints, Grievances, and Appeals The MCO is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals Member Grievance System reports due date: 15th day of following calendar month for 1st 6 months than 45 calendar days following most recent quarter	**Documents** Policy/procedure **Reports** Member Grievance System reports for grievances, appeals, expedited appeals and state fair hearings submitted during the review period	Full	The requirement is partially addressed in policy/procedure NE.QI.11, page 5, section A-13; policy/procedure NE.UM.08, page 10, section X; and screenshots and documentation of grievance system reports provided by the MCO.	