

NEBRASKA

Good Life. Great Mission.

Department of Health and Human Services
Division of Medicaid and Long-Term Care

2025 Quality Strategy Evaluation

September 2026

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



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1. Quality Strategy

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.340, the Department of Health and Human Services (DHHS) implemented a written Quality Strategy for assessing and improving the quality and health care services furnished by the three managed care organizations (MCOs).

The Nebraska Medicaid Managed Care Program, known as Heritage Health, integrates physical health, behavioral health (BH), dental, and pharmacy services into a single, comprehensive, and coordinated delivery system for Medicaid and Children’s Health Insurance Program (CHIP) members. Historically, Nebraska implemented managed care through the Nebraska Health Connection program in 1995 under Section 1915(b) waiver authority. BH services were administered separately prior to transitioning to a capitated, full-risk managed care model in September 2013. Heritage Health was subsequently implemented to further integrate services across managed care programs.

The *Quality Strategy for Heritage Health Program 2023* (referred to as Quality Strategy in this report) was written by the Division of Medicaid and Long-Term Care (MLTC) and filed with the Centers for Medicare & Medicaid Services (CMS) in 2023. The goals and objectives for the Heritage Health program directly reflect the Quadruple Aim of improving member experience of care, provider experience, and the health of populations, and ensuring the long-term financial viability of the Medicaid program.

Beginning on January 1, 2024, the Heritage Health program included Molina Healthcare of Nebraska, Inc. (MHN), Nebraska Total Care, Inc. (NTC), and UnitedHealthcare Community Plan of Nebraska, Inc. (UHCCP), which served all Medicaid and CHIP members statewide.

2. Goals and Objectives

Nebraska's Quality Strategy identifies the following four aims, 12 goals, and associated objectives:

Table 2-1—Aims, Goals, and Objectives of Heritage Health Program

Aims	Goals	Objectives
1. Improve the Member Experience of Care 	1. Enhance integration of services and whole person care.	Integrate dental care into Heritage Health contracts.
		Update non-emergency medical transportation regulations to allow for additional transportation flexibility.
	2. Expand access to high-quality services to meet the needs of diverse clients.	Update telehealth regulations to improve access to care.
		Ensure timely access to primary and specialty care.
	3. Improve coordination of care.	Ensure appropriate follow-up after emergency department (ED) visits and hospitalizations through effective care coordination and case management.
2. Improve the Provider Experience of Care 	4. Increase member satisfaction.	Engage with enrollees to improve enrollee experience and outcomes and increase public awareness about services.
	5. Timely decision making.	Ensure timely payment for claims.
		Resolve appeals in a timely manner.
	6. Increase provider satisfaction.	Streamline provider credentialing by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialing verification subcontractor.
	7. Build transparent and trusting stakeholder relationships.	Conduct regular “listening sessions” where relevant MLTC leadership meet with provider and community constituents at least quarterly to solicit their ideas, suggestions, and feedback for incorporation into policies and program improvements when/where possible.
3. Improve the Health of Populations 	8. Promote wellness and prevention.	Improve screening rates for cancers.
		Promote oral health.
		Ensure access to care during pregnancy, childbirth, and postpartum.
		Promote healthy development and wellness in children and adolescents.
		Improve immunization rates.
		Ensure appropriate use of prescription drugs.

Aims	Goals	Objectives
	9. Improve chronic disease management and control.	Improve hypertension, diabetes, and cardiovascular disease management and control.
		Improve access to mental health and substance use disorder (SUD) care.
	10. Identify and implement initiatives to close care gaps and address health disparities for underserved communities.	Advance interventions which address social determinants of health (SDOH).
		Identify enrollees who are experiencing homelessness and provide care coordination and case management.
4. Reduce the Per Capita Cost of Health Care 	11. Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions.	Identify potential enrollees who are transitioning from incarceration and provide support through the eligibility process and their reentry into the community.
		Reduce the number of ED visits for SUDs.
		Increase the percentage of adults who initiate and continue treatment after diagnosis of alcohol or other drug abuse/dependence.
	12. Pay for value and incentive innovation.	Improve maternal health and reduce the pre-term birth rate in Medicaid beneficiaries.
		Incorporate into Heritage Health contracts incentives for improving health outcomes.

Each of the 25 objectives is tied to a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a series of quality measures. MLTC will be monitoring the quality measures in order to evaluate the effectiveness of the Quality Strategy.

3. Evaluation

Health Services Advisory Group, Inc. (HSAG), as the External Quality Review Organization (EQRO) for Nebraska, conducted a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve health care delivery, accessibility, and quality in the populations served by the Heritage Health program.

Methodology

To evaluate the Quality Strategy, HSAG analyzed the following to determine performance and progress in achieving the goals of the Quality Strategy:

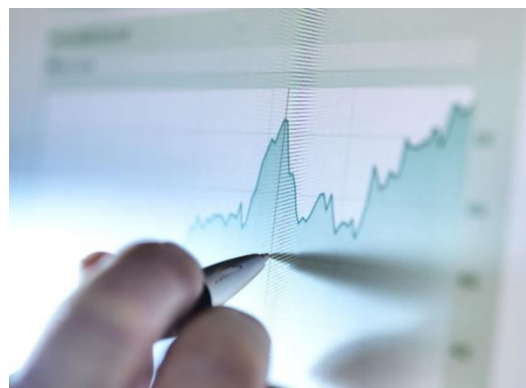
- Quality initiatives
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹ surveys
- Performance measure data
- External quality review (EQR) activities
 - Validation of performance improvement projects
 - Validation of performance measures
 - Assessment of compliance with Medicaid managed care regulations
 - Validation of network adequacy
 - Annual EQR technical report

Review Period

The evaluation review period focuses on performance measure data from measurement year (MY) 2024, and EQR activity results from contract years (CYs) 2024 through 2026.

Evaluation Tool

To track the progress of achieving goals and objectives outlined in the Quality Strategy, HSAG developed a Nebraska Medicaid Goals Tracking Table, as shown in Appendix A. The table comprises the metrics included in the 2023 Quality Strategy for Heritage Health Program Managed Care Entity (MCE) Performance Measures



¹ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Appendix A and is categorized by the State's associated aims, goals and objectives, along with MY 2024 quality measure targets and evaluation.

Evaluation of Quality Strategy Effectiveness

MLTC uses several mechanisms to monitor and enforce MCO compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care members. The following sections provide an overview of the key mechanisms MLTC uses to enforce these standards and to identify ongoing opportunities for improvement.



Quality Initiatives

MLTC has implemented a series of initiatives aligned closely to the Quality Strategy and designed to build a person-centered, coordinated system of care that addresses both medical and non-medical drivers of health. These initiatives drive progress toward the Quality Strategy goals and objectives, and are discussed below.

Improve Population Health Outcomes

The MCOs must include the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers.

As required by DHHS and federal managed care regulations, each MCO must implement CMS-validated performance improvement projects (PIPs), which are among the most direct levers for improving population health. These projects target measurable improvement across entire member populations rather than individual care episodes. Results are externally validated through Nebraska's EQRO process.

Nebraska's Heritage Health program prioritizes early-life interventions that have long-term population health impact. Key initiatives include:

- Prenatal care timeliness and adequacy.
- Tetanus, diphtheria, and acellular pertussis vaccination during pregnancy.
- Postpartum visit compliance.
- Early and Periodic Screening, Diagnostic, and Treatment services.
- Well-child visit frequency in the first 15 months of life.

A core population health objective of Heritage Health is improving outcomes for individuals with mental health and SUDs. Major quality initiatives include:

- Integration of BH into managed care contracts.
- Required follow-up after hospitalization for mental illness.
- Coordination under Nebraska's Section 1115 SUD Demonstration Waiver.
- Expansion of community-based BH services.

These efforts aim to reduce avoidable hospitalizations, improve recovery outcomes, and address rising BH needs statewide.

Nebraska has embedded value-based purchasing (VBP) into Heritage Health to align financial incentives with population health improvement. VBP mechanisms include:

- Incentive payments tied to quality performance.
- Penalties or withholds for failing to meet benchmarks.
- Directed payments supporting quality initiatives through partners such as the University of Nebraska Medical Center (UNMC).

This shifts the system away from volume-based care toward prevention, outcomes, and equity.

Population health improvement is reinforced through public reporting of quality measures, including:

- Preventive care rates.
- Maternal and child health indicators.
- Service utilization trends.
- Selected outcome metrics across MCOs.

Heritage Health emphasizes targeted care management for individuals with complex needs, including:

- Medically complex children.
- Individuals with multiple chronic conditions.
- Justice-involved youth.
- People with disabilities or serious mental illness.

These initiatives improve population health by preventing fragmentation, reducing avoidable utilization, and supporting long-term functional outcomes. Furthermore, Heritage Health improves population health by prioritizing prevention, early intervention, integrated BH care, and accountability for outcomes across its Medicaid population.

Identify Disparities in Health Care

The MCOs are required to identify disparities in health care access, service provision, satisfaction, and outcomes. This includes obtaining data on member demographics and SDOH, and stratifying MCO data such as claims, Healthcare Effectiveness Data and Information Set (HEDIS[®])² measures, CAHPS surveys, health risk assessments (HRAs), and member-identified race, ethnicity, geography, language, and SDOH to determine populations with the highest needs.

Populations experiencing reduced access to care include:

- Rural members, particularly in frontier counties, due to provider shortages, travel distance, and limited specialty and BH availability.
- Members with limited English proficiency (LEP) who face challenges navigating care and scheduling services.
- Individuals with disabilities or complex medical needs who encounter network adequacy and care coordination barriers.

Access disparities are identified through stratified network adequacy reviews, claims data, grievances, and HEDIS access measures by geography and language.

Analysis of claims, HEDIS measures, and HRAs shows disparities in:

- Preventive care use (e.g., well-child visits, immunizations, cancer screenings), especially among:
 - Racial and ethnic minority members.
 - Members with housing instability or transportation barriers.
- BH service utilization, particularly for:
 - American Indian/Alaska Native members.
 - Rural adults.
 - Justice-involved youth.

The MCOs stratify utilization data by race, ethnicity, SDOH indicators (housing, food insecurity), and geography to identify high-need populations.

Outcome disparities documented or targeted for improvement include:

- Maternal and infant health outcomes, with higher risks among:
 - Black and Indigenous mothers.
 - Women with limited prenatal care.
 - Members experiencing poverty-related SDOH.

² HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Chronic disease outcomes (e.g., asthma control, diabetes management), particularly among:
 - Low-income adults.
 - Rural residents.
 - Members with co-occurring BH conditions.

These disparities are identified through HEDIS outcome measures, PIP results, and EQRO-validated analyses, stratified by demographic and SDOH factors.

CAHPS survey stratification shows lower satisfaction among:

- Members reporting communication or language barriers.
- Individuals with mental health or SUDs.
- Members with unmet social needs such as transportation or housing instability.

Disparities in experience are monitored using CAHPS results, grievance data, and call center metrics, stratified by race, language, age, and disability status.

The MCOs are required to collect SDOH data through HRAs, care management encounters, and member self-report, identifying disparities related to:

- Food insecurity.
- Housing instability or homelessness.
- Transportation barriers.
- Limited social support.
- Members with one or more SDOH needs who show lower preventive care uptake, higher ED use, and poorer chronic disease outcomes, underscoring the need for targeted interventions to address social risk factors and improve health outcomes.

According to the MCO contract, the MCOs must:

- Stratify claims, HEDIS performance measure results, CAHPS survey results, HRA data, and enrollment data.
- Identify populations with the highest risk and unmet needs.
- Design PIPs and equity-focused interventions.
- Report findings through EQR and public dashboards.

In Nebraska's Heritage Health program, health disparities are most pronounced by race/ethnicity, rural geography, language, disability status, and SDOH burden, affecting access, service use, satisfaction, and outcomes. The MCOs are explicitly required to identify these disparities through data stratification and use the findings to drive population-level quality improvement.

MLTC advances health equity through structured leadership collaboration, data-driven oversight, and community engagement across the Heritage Health program.

Governance and Collaboration:

- Inter-divisional coordination: MLTC meets regularly (monthly, quarterly, and as needed) with DHHS' sister division's leadership to address shared priorities, discuss concerns, and strengthen coordinated approaches to health disparities.
- MCO leadership oversight: MLTC hosts monthly director's meetings with administrative, clinical, operational, and financial leaders from each MCO to review performance, quality, network adequacy, policy implementation, and health disparity initiatives.
- Clinical collaboration: MLTC convenes monthly clinical meetings with MCO medical leadership to review quality outcomes, identify barriers to care, develop solutions, and advance health equity.

Stakeholder and Beneficiary Engagement:

- MLTC hosts the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Committee (BAC) every two months, incorporating input from community stakeholders and Medicaid beneficiaries statewide.
- These forums ensure that policy and strategy implementation are informed by lived experience and trusted community voices.

Core Goals of the Health Disparities Plan:

1. Identify gaps in clinical care and SDOH and implement innovative solutions.
2. Use data to drive decisions, including root cause analysis of poor outcomes and disparities.
3. Apply evidence-based best practices to improve population health and reduce disparities.
4. Engage communities and beneficiaries as partners in policy and program implementation.
5. Sustain long-term solutions, including workforce capacity and data infrastructure, to ensure lasting impact.

MCO Health Disparities Committees (Effective January 1, 2024):

- All Heritage Health MCOs are required to establish a Health Disparities Committee.
- The committee's purpose is to:
 - Identify areas of health disparity.
 - Collaborate with members, providers, and communities.
 - Develop policies and care strategies to proactively reduce disparities.
- These committees operate under each MCO's Quality Assessment and Performance Improvement (QAPI) Program.

Nebraska’s Health Disparities Plan emphasizes cross-agency leadership alignment, data use, MCO accountability, and meaningful community engagement to systematically identify and reduce health disparities across the Medicaid population.

Requirement to Attain National Committee for Quality Assurance Accreditation

Standardized accreditation combined with the integration of physical health, BH, and dental programs allows MLTC to better evaluate quality and performance and provides for a clearer comparison between MCOs.

Nebraska requires all MCOs to be NCQA-accredited (or equivalent) and to maintain that accreditation throughout the contract term. MCOs that are not accredited at the outset must achieve accreditation within five years, with MLTC monitoring progress through contract oversight, accreditation reporting, and EQR.

All three MCOs currently hold NCQA Health Plan Accreditation, which satisfies Nebraska’s managed care contract and regulatory requirements. NCQA Health Plan Accreditation indicates that an MCO has undergone an independent evaluation and meets nationally recognized standards for quality, care delivery, and member experience. Additionally, it provides external validation of the MCO’s operations and supports MLTC’s oversight by confirming that the MCO meets established benchmarks for delivering quality care.

Table 3-1 displays NCQA accreditation levels and dates for the three MCOs, based on Nebraska MLTC-posted accreditation certificates and NCQA report cards.

Table 3-1—MCOs’ NCQA Accreditation Status³

MCO	NCQA Accreditation Level	Date Granted	Expiration Date
MHN	Accredited (Medicaid Health Maintenance Organization [HMO])	July 22, 2025	July 22, 2028
NTC	Accredited (Medicaid HMO)	February 21, 2025	February 21, 2028
UHCCP	Accredited (Medicaid HMO)	June 2, 2026	June 2, 2029

³ NCQA Accreditation Certificates and NCQA Health Plan Report Cards for MHN, NTC, and UHCCP, as posted by Nebraska DHHS MLTC and NCQA.

Value-Based Purchasing Initiatives

VBP requirements promote added value for members and providers by aligning the financial goals of the MCOs and providers. MLTC defines value-based contracts as payment and contractual arrangements between the MCOs and providers. The MCOs create partnerships with provider groups with the goal of adding value to care for both members and providers, expanding access to care, and closing gaps in quality metrics.

The MCOs are required to annually submit and present their VBP implementation plans to MLTC. As part of this process, the MCOs report on their VBP arrangements, performance metrics, outcomes, and progress in advancing quality improvement through value-based contracts. The annual presentations provide MLTC leadership with an opportunity to review each MCO's VBP strategy, discuss performance results, and evaluate how value-based contracting efforts are supporting improvements in healthcare quality and member outcomes.

Nebraska's Heritage Health VBP approach:

- Links payment to quality and outcomes.
- Holds MCOs accountable for provider-level value strategies.
- Uses PIPs and directed payments to drive population health improvement.
- Prioritizes preventive care, maternal health, BH, and equity.

This multi-layered VBP framework aligns Nebraska Heritage Health with CMS managed care best practices while maintaining flexibility at the MCO and provider level.

CAHPS

The MCO contract with DHHS, Division of MLTC, requires each MCO to administer the CAHPS survey, including engaging an approved survey vendor, and to report results in accordance with established guidelines.

The table in Appendix A tracks the following quality measures of the CAHPS survey:

- *Getting Care Quickly* Aggregated Question Response
- *Getting Needed Care* Aggregated Question Response
- *Health Plan Customer Service*
- *Rating of All Health Care* Aggregated Question Response

Quality Measures

Pursuant to contractual requirements established by DHHS, the MCOs are required to report annually on patient outcome quality measures, including the CMS Adult and Child Core Set measures, CAHPS measures, HEDIS quality measures, Dental Quality Alliance (DQA) measures, and additional performance measures as determined by MLTC.



As an appendix to the Quality Strategy, MLTC identifies the required quality measures and links them to each aim, goal, and objective. MLTC identifies the statewide performance baseline rate (if applicable/available) and the statewide performance target for each objective (if applicable/available). The goals are tied to a system by which the success of focused interventions can be measured to continually improve the quality of the Heritage Health program. Table 3-2 summarizes the statewide quality measure results and Quality Strategy targets met as shown in Appendix A—Medicaid Goals Tracking Table.

Table 3-2—Quality Strategy Aims Statewide Summary of Performance

	Aim 1— Improve the Member Experience of Care 	Aim 2— Improve the Provider Experience of Care 	Aim 3— Improve the Health of Populations 	Aim 4— Reduce the Per Capita Cost of Health Care 
Number of applicable MY 2024 quality measures reported	8	2	33	4
Number of applicable MY 2024 quality measures with an established target	8	2	33	4
Applicable MY 2024 quality measures achieving the target	2	1	13	1
Percentage of applicable MY 2024 quality measures achieving the target	25%	50%	39%	25%

Table 3-3 summarizes MCO performance relative to the MLTC Quality Strategy targets. Green shaded cells with a caret (^) indicate whether MCO performance for a given measure rate met or exceeded the target threshold established by MLTC. The performance measures in Appendix A represent MY 2024 measures reviewed by HSAG.

Table 3-3—Percentage of MLTC Quality Strategy Targets Met or Exceeded

Measure	Performance
Aim 1 Goal—Expand access to high-quality services to meet the needs of diverse clients	
EQRO NAV evaluation	NA
CAHPS Survey— <i>Getting Care Quickly</i> Aggregated Question Response	Met^
CAHPS Survey— <i>Getting Needed Care</i> Aggregated Question Response	Met^
Aim 1 Goal—Improve coordination of care	
<i>Follow-Up After ED Visit for Mental Illness (FUM)—30-Day Follow-Up</i>	Not Met
<i>Follow-Up After ED Visit for Mental Illness (FUM)—7-Day Follow-Up</i>	Not Met
<i>Follow-Up After ED Visit for Substance Use (FUA)—30-Day Follow-Up</i>	Not Met
<i>Follow-Up After ED Visit for Substance Use (FUA)—7-Day Follow-Up</i>	Not Met
<i>Ambulatory Care: ED Visits (AMB)</i> *per 12,000 beneficiary months, per HEDIS, to include all age groups	Discontinued
Aim 1 Goal—Increase member satisfaction	
CAHPS Survey— <i>Health Plan Customer Service</i> Aggregated Question Response	Not Met
CAHPS Survey— <i>Rating of All Health Care</i> Aggregated Question Response	Not Met
Aim 2 Goal—Timely decision making	
Claims Processing Timeliness Quality Performance Program (QPP): Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 10 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	Not Met
Appeal Resolution Timeliness QPP: MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	Met^
Aim 2 Goal—Increase provider satisfaction	
Provider Survey	NA
Aim 2 Goal—Build transparent and trusting stakeholder relationships	
Provider Survey	NA

Measure	Performance
Aim 3 Goal—Promote wellness and prevention	
<i>Breast Cancer Screening (BCS)</i>	Met [^]
<i>Colorectal Cancer Screening (COL)</i>	Met [^]
<i>Cervical Cancer Screening (CCS)</i>	Not Met
<i>Oral Evaluation, Dental Services (OEV-CH)</i>	Not Met
<i>Topical Fluoride for Children (TFL-CH)</i>	Met [^]
<i>Sealant Receipt on Permanent First Molars (SFM-CH)</i>	Met [^]
<i>Periodontal Evaluation in Adults with Periodontitis (PEV-A)</i>	Not Met
<i>Prenatal and Postpartum Care—Postpartum Care (PPC)</i>	Met [^]
<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)— Most/Moderately Effective (MMEC)—3 Days</i>	Not Met
<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)— MMEC—90 Days</i>	Met [^]
<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)— Long-Acting Reversible Contraception (LARC)—3 Days</i>	Not Met
<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)— LARC—90 Days</i>	Met [^]
<i>Contraceptive Care—Postpartum Women—Ages 21 to 44 Years (CCP-AD)— MMEC—3 Days</i>	Not Met
<i>Contraceptive Care—Postpartum Women—Ages 21 to 44 Years (CCP-AD)— MMEC—90 Days</i>	Met [^]
<i>Contraceptive Care—Postpartum Women—Ages 21 to 44 Years (CCP-AD)— LARC—3 Days</i>	Not Met
<i>Contraceptive Care—Postpartum Women—Ages 21 to 44 Years (CCP-AD)— LARC—90 Days</i>	Met [^]
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>	Not Met
<i>Child and Adolescent Well-Care Visits (WCV)</i>	Met [^]
<i>Lead Screening in Children (LSC)</i>	Met [^]
<i>Immunizations for Adolescents (IMA)—Combination 2</i>	Not Met
<i>Childhood Immunization Status (CIS)—Combination 10</i>	Not Met
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	Not Met
<i>Asthma Medication Ratio (AMR)</i>	Not Met

Measure	Performance
Aim 3 Goal— Improve chronic disease management and control	
<i>Controlling High Blood Pressure (CBP-AD)</i>	Not Met
<i>Diabetes Short-Term Complications Admission Rate (PQI01)</i> *per 100,000 beneficiary months	Not Met
1115 SUD Metric #11—Withdrawal Management	Not Met
1115 SUD Metric #12—Medication Assisted Treatment	Not Met
<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)—Initiation Phase</i>	Not Met
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)—Continuation and Maintenance Phase</i>	Not Met
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)—Blood Glucose</i>	Not Met
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)—Cholesterol</i>	Met^
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)—Blood Glucose and Cholesterol</i>	Met^
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)</i>	Not Met
Aim 4 Goal— Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions	
1115 SUD Metric #23—ED Utilization for SUD per 1,000 Medicaid Beneficiaries	Not Met
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)—Initiation of SUD Treatment</i>	Not Met
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)—Engagement of SUD Treatment</i>	Not Met
<i>Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)</i>	Met^
Total Applicable MLTC Targets Met for MY 2024	17
Total Applicable MLTC Targets for MY 2024	47
Percentage of MLTC Targets Met for MY 2024	36%

External Quality Review Activities

As noted in the Quality Strategy, the EQRO plays a critical role in reporting MCO performance in several required areas (meaning federal regulations require that these activities be completed by the EQRO) and some optional areas (meaning that the State has elected to use the EQRO for these activities) under 42 CFR §438.352 and §438.364.

Validation of Performance Improvement Projects (PIPs)

The MCOs have an ongoing program of PIPs intended to continually improve the quality, access, and timeliness of care provided to their members. The MCOs conduct PIPs, which require a concerted effort to improve a particular problem, condition, or systemwide concern. MLTC and HSAG continued to work with the MCOs in annual PIP submission processes to facilitate more efficient and long-term sustained improvement. HSAG provided ongoing support as the MCOs completed quality improvement activities.

The EQRO validated each PIP during CY 2025–2026, and provided results and findings for each MCO, along with recommendations for improvement. The MLTC-selected PIPs are listed in Table 3-4 along with the results.



Table 3-4—CY 2025–2026 PIP Validation Results for Each MCO

MCO	PIP Topic	Clinical or Nonclinical Topic	Validation Rating 1—Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP	Validation Rating 2—Overall Confidence That the PIP Achieved Significant Improvement
MHN	<i>Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years</i>	Clinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>
MHN	<i>Health Risk Screener Completion in Pregnant Members</i>	Nonclinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>
NTC	<i>Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years</i>	Clinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>
NTC	<i>Health Risk Screener Completion in Pregnant Members</i>	Nonclinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>
UHCCP	<i>Increasing Chlamydia Screening Rates in Sexually Active Women Ages 16–24 Years</i>	Clinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>
UHCCP	<i>Health Risk Screener Completion in Pregnant Members</i>	Nonclinical	<i>High Confidence</i>	<i>Not Assessed⁴</i>

⁴ *Not Assessed*—HSAG did not assess Validation Rating 2 as the MCO reported the baseline data only for each PIP.

Validation of Performance Measures

For CY 2025–2026, MLTC selected a subset of NCQA HEDIS measures as performance measures, with calendar year 2024 serving as the measurement period for validation. Developed and maintained by NCQA, HEDIS is a widely recognized set of performance measures used across the managed care industry. In addition to HEDIS measures, MLTC selected physical, behavioral, and dental health measures from the CMS Adult and Child Core Sets. The MCOs reported HEDIS performance measures and underwent an NCQA HEDIS Compliance Audit.⁵ From these, MLTC identified a subset of HEDIS and Core Set measures for ongoing monitoring, as detailed in Appendix A.

Assessment of Compliance With Medicaid Managed Care Regulations

During CY 2025–2026, HSAG conducted a compliance review of each MCO to review compliance with federal regulations and State contract requirements. In general, MCO performance suggested that all MCOs had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Nebraska. One standard, Quality Assessment and Performance Improvement, was found to be fully compliant (i.e., 100 percent of standards/elements met) across all MCOs. Additionally, all but one MCO scored 100 percent for Provider Selection and Program Integrity, Subcontractual Relationships and Delegation, and Health Information Systems. Only one MCO was found to be fully compliant with the Enrollment and Disenrollment standard.



Table 3-5 summarizes the results from the CY 2025–2026 compliance monitoring reviews. This table contains high-level results used to compare the Nebraska Medicaid MCOs’ performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review. Scores have been calculated for each standard area statewide, and for each MCO for all standards. MCO scores with green shading and a caret (^) indicate performance at 100 percent.

Table 3-5—Standards and Compliance Scores

	Standard Name	MHN	NTC	UHCCP	Statewide Score
I	Enrollment and Disenrollment*	100%^	90%	50%	80%
II	Member Rights and Confidentiality	67%**	100%**	100%**	89%**
III	Member Information	86%**	100%**	96%**	94%**

⁵ HEDIS Compliance Audit™ is a trademark of the NCQA.

	Standard Name	MHN	NTC	UHCCP	Statewide Score
IV	Emergency and Poststabilization Services	100%**	100%**	100%**	100%**
V	Adequate Capacity and Availability of Services*	89%	83%	94%	89%
VI	Coordination and Continuity of Care	100%**	100%**	100%**	100%**
VII	Coverage and Authorization of Services	84%**	100%**	95%**	93%**
VIII	Provider Selection and Program Integrity*	89%	100% [^]	100% [^]	96%
IX	Subcontractual Relationships and Delegation*	100% [^]	86%	100% [^]	95%
X	Practice Guidelines	100%**	100%**	100%**	100%**
XI	Health Information Systems*	100% [^]	89%	100% [^]	96%
XII	Quality Assessment and Performance Improvement*	100% [^]	100% [^]	100% [^]	100% [^]
XIII	Grievance and Appeal System	92%**	92%**	100%**	95%**
	Totals	92%	96%	96%	95%

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

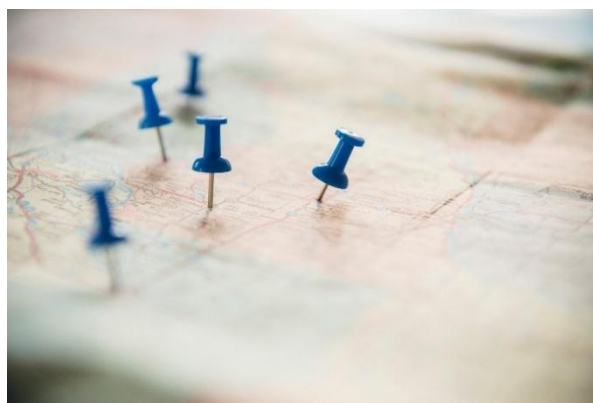
**Grey shading indicates standards that were reviewed during CY 2024–2025.

Totals: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

For the elements within each standard that were not fully compliant, the MCOs were required to develop a corrective action plan (CAP), which was reviewed by the EQRO and MLTC. CAPs were approved when it was determined that the CAP would bring the MCO into compliance with the requirements. HSAG, along with MLTC, provided ongoing monitoring of the implementation of the CAPs.

Validation of Network Adequacy Validation (NAV)

Within the Quality Strategy, MLTC established provider network standards to ensure that members have timely access to care. MCOs must ensure that their networks have a sufficient number, mix, and geographic distribution of providers to offer an appropriate range of services and access to preventive, primary, acute, BH, and long-term services and supports. Additionally, the MCOs are required to maintain a minimum number of providers within a particular geographic area. In addition to the minimum required providers, the MCOs are required to have a sufficient network to ensure that members can obtain needed health services within acceptable wait times. To monitor network adequacy, MLTC requires that the MCOs submit a quarterly GeoAccess Report. The MCOs are also required to establish



and monitor policies and procedures to ensure that network providers comply with acceptable wait times and take corrective action when they fail to comply.

Table 3-6 presents the NAV results for CY 2025–2026, with data collected as of March 31, 2025. It displays the percentage of each MCO’s members with access to providers within the geographic access standards established by MLTC. Findings are stratified by provider category and urbanicity, where applicable. Results are reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results are reported statewide.

Table 3-6—Percentage of Members With Required Access to Care by Provider Category and MCO

Provider Category	MHN	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
Primary Care Physician (PCP), Urban	100.0%	100.0%	100.0%
PCP, Rural	100.0%	>99.9%^	100.0%
PCP, Frontier	100.0%	100.0%	100.0%
High-Volume Specialists**			
<i>Cardiology</i>	99.9%^	100.0%	>99.9%^
<i>Neurology</i>	100.0%	100.0%	>99.9%^
<i>Obstetrics and Gynecology</i>	100.0%	100.0%	100.0%
<i>Oncology-Hematology</i>	99.7%^	99.8%^	99.8%^
<i>Orthopedics</i>	100.0%	100.0%	100.0%
Pharmacy, Urban	96.6%	95.8%	96.3%
Pharmacy, Rural	91.9%	91.4%	93.4%
Pharmacy, Frontier	97.7%	97.5%	97.8%
All BH Inpatient and Residential Service Providers, Urban	100.0%	100.0%	100.0%
All BH Inpatient and Residential Service Providers, Rural	100.0%	100.0%	100.0%
All BH Inpatient and Residential Service Providers, Frontier	100.0%	100.0%	100.0%
All BH Outpatient Assessment and Treatment Providers, Urban	>99.9%^	>99.9%^	>99.9%^
All BH Outpatient Assessment and Treatment Providers, Rural	>99.9%^	99.9%^	>99.9%^
All BH Outpatient Assessment and Treatment Providers, Frontier	99.8%^	97.7%^	98.3%^
Hospitals	99.1%^	99.4%^	99.2%^
Optometry, Urban	95.2%^	>99.9%^	>99.9%^
Optometry, Rural	85.3%^	>99.9%^	>99.9%^
Optometry, Frontier	76.3%^	100.0%	100.0%
Ophthalmology, Urban	97.6%^	98.0%^	98.1%^
Ophthalmology, Rural	>99.9%	100.0%	100.0%

Provider Category	MHN	NTC	UHCCP
	Percent of Members With Required Access*	Percent of Members With Required Access*	Percent of Members With Required Access*
Ophthalmology, Frontier	87.5%^	100.0%	91.3%^
Dental			
Dentist, Urban	>99.9%^	100.0%	100.0%
Dentist, Rural	99.9%^	>99.9%^	99.9%^
Dentist, Frontier	100.0%	100.0%	100.0%
Dental Specialists			
<i>Oral Surgeon, Urban</i>	73.9%^	92.9%	88.6%
<i>Oral Surgeon, Rural</i>	57.1%^	78.7%	65.2%^
<i>Oral Surgeon, Frontier</i>	18.0%^	55.2%^	22.4%^
<i>Orthodontist, Urban</i>	82.2%^	84.7%^	83.0%^
<i>Orthodontist, Rural</i>	50.7%^	67.6%^	58.7%^
<i>Orthodontist, Frontier</i>	79.1%	100.0%	78.4%
<i>Periodontist, Urban</i>	59.0%^	23.6%^	76.8%^
<i>Periodontist, Rural</i>	18.6%^	29.3%^	37.5%^
<i>Periodontist, Frontier</i>	0.0%^	0.0%^	0.0%^
<i>Endodontist, Urban</i>	59.0%^	72.7%^	76.8%^
<i>Endodontist, Rural</i>	18.6%^	33.5%^	37.9%^
<i>Endodontist, Frontier</i>	0.0%^	0.0%^	0.0%^
<i>Prosthodontist, Urban</i>	59.0%^	51.7%^	76.8%^
<i>Prosthodontist, Rural</i>	19.3%^	18.3%^	37.6%^
<i>Prosthodontist, Frontier</i>	0.0%^	0.0%^	0.0%^
<i>Pediadontist, Urban</i>	96.7%	97.5%	97.5%
<i>Pediadontist, Rural</i>	83.5%	79.5%	84.4%
<i>Pediadontist, Frontier</i>	84.6%	85.4%	86.8%

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

*The minimum access is required for 100 percent of members unless otherwise noted.

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

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
	messages to ensure members return for yearly screening.		<i>Visits (WCV)</i> during telephonic interaction with the member or authorized representative. - The MCOs also utilize Community Health Workers (CHW) to complete targeted outreaches which includes education to authorized representatives regarding the body mass index (BMI) assessment, nutritional and physical activity counseling by providers at well-child visits. - The MCOs provide education to providers through their clinical provider representatives. Practitioners and/or clinics are provided with updated member specific compliance data and education. Specific to the <i>WCC</i> measure, the clinical provider representatives discuss the importance of documenting BMI, nutrition, and physical activity counseling in the member's medical record in accordance with NCQA guidance. - The MCOs have offered providers the opportunity to engage in Value Based Contracting (VBC) to address opportunities in care and have implemented VBCs on <i>WCC</i> over the course of several years. - The MCO Chief Medical Officer (CMO) engages in ongoing education and discussion at various meetings with providers on approaches to improve <i>WCC</i> screening rates, as well as documentation regarding BMI, nutrition, and physical activity counseling.

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
			- The MCOs conduct various communication campaigns such as interactive voice recording reminders and educational mailers to prompt members to schedule appointments and close the identified gap in care. - Member incentives are offered as gift cards to members who schedule and attend an appointment to complete their annual well-child visit. Eligibility for this program is based off the <i>WCV</i> measure to provide reminders of the need for annual preventive care appointments. - Member education is also provided via the Member Handbook and Member Portal regarding the importance of an annual well-child visit, as well as language that specifically addresses that the exam should include weight (BMI) assessment, counseling for nutrition, and counseling for physical activity.
Quality	HSAG recommended that MLTC conduct a root cause analysis to ensure that the MCOs are aware of appropriate treatments for upper respiratory infection (URI). Additionally, HSAG recommended that MCO providers evaluate their noncompliant claims to confirm there were no additional diagnoses during the appointment that justify the prescription of an antibiotic.	Timely decision making. Promote wellness and prevention.	- One of the MCOs has created a workgroup to address Antibiotic stewardship as it relates to URI and Acute bronchitis. The workgroup has completed a root cause analysis and pulls a list of the lower performing providers. The CMO provides education through webinars etc. with a discussion on the current literature on the overuse of antibiotics. - The MCOs are working on identifying noncompliant claims for any additional diagnoses that would justify the prescription of an antibiotic.

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
Quality, Timeliness, and Access	HSAG recommended that MLTC work with the MCOs to determine root causes and barriers preventing members with a new SUD episode from receiving timely initiation of SUD treatment. Early and regular SUD treatment, including medication therapy, has been demonstrated to improve outcomes for individuals with SUDs.	Improve chronic disease management and control.	- MLTC tied QPP dollars to incentivize MCO performance in the HEDIS measure <i>Initiation and Engagement of SUD Treatment (IET)</i> since 2021. - The MCOs send out emails and portal messages to members identified with an open <i>IET</i> gap. - The MCO Care and Case Managers conduct outreach to members following ED visits and hospital discharges related to substance use. Outreach includes providing education on the importance of timely follow up care, assisting with appointment scheduling, coordinating transportation, and assessing for additional SDOH needs. - The MCO pharmacist is used to review reports of members with new prescriptions for medications used to treat alcohol and opioid use disorders. CHWs contact these members to confirm they received their medications, have scheduled follow up appointments, and have access to transportation. - All identified members are offered the opportunity to enroll in Case Management services. - The <i>IET</i> HEDIS measure is difficult because: - Of the complexity of the technical specifications of the measure and inconsistencies in coding, - CFR 42 poses a barrier to the ability to communicate with providers, and

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
			Limited availability of providers who provide medication assisted treatment (MAT).
Quality and Access	HSAG recommended that MLTC work with the MCOs to implement targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. HSAG also recommends that the MCOs identify best practices for ensuring children receive timely and medically appropriate well-care services.	Expand access to high-quality services to meet the needs of diverse clients. Promote wellness and prevention.	- MLTC contractually requires each MCO to have a Health Equity committee and to have health equity representation on their other healthcare committees. Other contractual requirements include tribal representation and the Member Advisory Committee. - The MCOs use data and dashboards to identify disparities and address HEDIS measures in context of the findings. - One MCO sends out Provider Profiles that include disparate groups —specifically for measures <i>Breast Cancer Screenings</i> and <i>Colorectal Cancer Screenings</i>. - Some MCOs are participating in a Doula pilot. - The MCOs, in accordance with NCQA accreditation, conduct an annual disparities analysis that includes at least three valid clinical measures and one member experience measure stratified by race/ethnicity, language, and at least one additional demographic factor such as age. HEDIS measures studied include <i>WCV</i>, <i>PPC</i>, <i>CHL</i>. Findings are used to implement targeted intervention to reduce observed disparities informed by the results of a completed root cause analysis. - One MCO identified three counties that were at highest risk for Lead and started targeted Lead screening

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
			outreach (Douglas, Lancaster, and Burt). This outreach will be completed by the end of March 2026 and outreach to additional counties will then begin. Quarterly text messaging for Lead screening has also been launched. • MLTC has tied QPP dollars to incentivize MCO performance in the <i>HEDIS measure Well-Child Visit</i> in 2025. • The MCOs identify members with specific HEDIS gaps for outreach. The case management team addresses care gaps in <i>WCV</i> during telephonic interaction with the member or authorized representative. • The MCOs also utilize CHWs to complete targeted outreaches which includes education to authorized representatives. • The MCOs provide education to providers through their clinical provider representatives. Practitioners and/or clinics are provided with updated member specific compliance data and education. • The MCOs have offered providers the opportunity for incentive payments and to engage in VBC to address opportunities in care and implemented VBCs on <i>WCV</i> over the course of several years. • Member incentives are offered as gift cards to individuals who schedule and attend an appointment to complete their annual well-child visit. Eligibility for this program is based off the <i>WCV</i> measure to

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
			provide reminders of the need for annual preventive care appointments. Member education is also provided via text messaging, audiovisual aids (videos), the Member Handbook and Member Portal regarding the importance of an annual well-child visit.
Quality, Timeliness, and Access	HSAG recommended that MLTC work with each MCO to review the compliance monitoring report and its detailed findings and recommendations. Specific recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.	Promote wellness and prevention.	MLTC agrees with HSAG's recommendation and will work collaboratively with each MCO to review the compliance monitoring report, including detailed findings and recommendations, to ensure appropriate follow-up and corrective actions.
Quality, Timeliness, and Access	HSAG recommended that MLTC revise MCO contract requirements to remedy operational and reporting practices and processes for the informal reconsideration and peer-to-peer processes. The MCOs' review of prior authorization denials with the enrollees' providers after the MCOs send enrollees notices of adverse benefit determination (NABDs) is consistent with CMS' definition of an appeal. MLTC should work with the MCOs to ensure appropriate initial prior authorization decisions, designate informal reconsiderations and peer-to-peer discussions as appeals, confirm enrollees' consent for providers to appeal on their behalf, validate that the content within the NABDs is consistent with the requirements,	Timely decision making.	MLTC acknowledges HSAG's position that post decision discussions that result in a change in outcome are being viewed as functionally equivalent to an appeal once an NABD has been issued. The intent with reconsiderations is the opportunity for the provider to submit missing or additional medical documentation and the intent for the peer to peer discussion is clinical dialogue and clarification, not an alternative appeal pathway. An alternative approach would be to allow post decision reconsiderations and peer to peer discussions to occur but treat them as non-determinative, meaning the adverse determination is not overturned outside of the formal appeal process. That framework preserves appeal rights and reporting integrity while still supporting provider

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
	and accurately report appeals information to MLTC.		communication. However, this may lead to additional provider abrasion with having to rely on formal processes (and additional administrative burden) to communicate additional information that may support an overturn. Reconsiderations and peer-to-peer discussions prior to determination are limited due to the regulatory turnaround time necessary for decision making.
Access	HSAG recommended that MLTC work with the MCOs on the provider categories for which the MCOs did not meet the time/distance standard. Additionally, HSAG recommends that the MCOs assess whether this is due to lack of providers available for contracting in the area, the lack of providers willing to contract with the MCOs, the inability to identify the providers in the data, or for other reasons.	Build transparent and trusting stakeholder relationships.	MLTC agrees with HSAG's recommendation and will work with the MCOs regarding the provider categories they did not meet the time/distance standard and request the MCOs assess the reasons for non-compliance.
Access	HSAG recommended that MLTC collaborate with the MCOs to continue exploring best practices and incentive programs that other organizations may have used to increase member access to care. In addition, the MCOs should solicit guidance from MLTC on strategies that could be employed to address gaps in access to care where observed.	Expand access to high-quality services to meet the needs of diverse clients. Pay for value and incentive innovation.	- The MCOs use a combination of network, member engagement, provider incentives, and operational strategies to improve timely and equitable access to care. Improving member access to care is most effective with the combination of: - Strong network adequacy, - Proactive and multimodal member outreach, - Appropriately designed member and provider incentive programs, - Interventions that address nonclinical barriers, and - Ongoing, equity focused data monitoring. These approaches support timely access to services, improved preventive care

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
			utilization, and better overall member outcomes while aligning with managed care requirements and quality expectations. • Member experience surveys: these surveys provide insight into opportunities for improvement such as transportation, access to dental services and coverage for pharmaceutical products. • One MCO sends mobile dental and vision vans into rural Nebraska to provide services. • The MCOs collaborate closely with Community Based Organizations and the FQHCs. Opportunities for improvement include enhancing school-based care and targeting sports physicals to be well-child visits when the elements of the member's evaluation can be incorporated appropriately. • The MCOs use member incentive programs to encourage the use of preventive and routine care: – The MCOs offer member incentives for completing preventive visits, screenings, health risk assessments, or other health promoting activities, and – Align member incentives with provider incentives and evaluate these incentive programs for effectiveness and equity impacts.
Quality, Timeliness, and Access	To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MLTC should update the contracts with its MCOs as follows within the required effective dates for each specific requirement:	Timely decision making. Increase member satisfaction.	• This is a contract requirement and is currently live for the MCOs since January 1, 2025. • The MCOs are implementing CMS Interoperability requirements to post prior authorization data on their

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
	- Require the MCOs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. - Require the MCOs to publicly report prior authorization data for members and providers to better understand the types of items and services that require prior authorization and how each MCO performed over time for approvals and denials. This requirement is to ensure transparency and accountability in the health care system and allow for the efficiency of prior authorization practices of each MCO, and enables the MCOs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining necessary checks for quality and appropriateness of care.	Increase provider satisfaction.	websites by the compliance date of March 31, 2026.
Quality, Timeliness, and Access	To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), MLTC should implement the following within the required effective dates for each specific requirement: Review the maximum appointment wait time standards (e.g., 10 business days for outpatient mental health and SUD appointments)	Expand access to high-quality services to meet the needs of diverse clients. Increase member satisfaction.	MLTC agrees with HSAG regarding the maximum appointment wait times. We will review and update the contract as needed. Thank you for the recommendation to contract with a vendor to perform secret shopper surveys of MCO compliance with appointment wait times and accuracy of provider directories. We will discuss this further internally.

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
	and update its contracts with its MCOs, as applicable. - Contract with an independent vendor to perform secret shopper surveys of MCO compliance with appointment wait times and accuracy of provider directories, and require directory inaccuracies to be sent to MLTC within three days of discovery. Results from the secret shopper survey will provide assurances to MLTC that the MCOs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members. - Conduct an annual member experience survey, by MLTC or its contracted vendor, to ensure consistency in administration within its managed care program. Because the member experience survey results will provide direct and candid input from members, MLTC and its MCOs can use the results to determine if their networks offer an appropriate range of services and access as well as if they provide a sufficient number, mix, and geographic distribution of providers to meet their members' needs. MLTC will be required to post the results of the survey on its website		Thank you for the recommendation to conduct an annual member experience survey. We will discuss this further internally.

Program Recommendations			
Domain	Recommendations	Associated Quality Strategy Goal(s)	MLTC Response
	annually in accordance with 42 CFR §438.10(c)(3).		

* Please note, content included in the “MLTC Response” section is presented verbatim as received from the State and has not been edited or validated by HSAG.

4. Strengths and Recommendations

Strengths

MLTC's Quality Strategy provides the roadmap to achieve its vision of healthy families and healthy communities. MLTC continually monitors, assesses, and implements strategies to improve access to quality care. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Nebraska's Heritage Health program.



The results of the PIPs, HEDIS measures, compliance review, and NAV indicate that the MCOs have established an operational foundation to support the quality of, access to, and timeliness of care and service delivery.

Overall, the PIPs demonstrated strong governance, methodological soundness, collaborative infrastructure, and measurable improvement in selected priority areas, supporting sustained advancement of quality, access, and member experience across the Heritage Health program.

For each PIP, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology for Validation Rating 1. For next year's validation, when the MCOs report Remeasurement 1 results, HSAG will also assign a confidence level to each PIP for Validation Rating 2, which assesses whether the PIP achieved significant improvement.

Overall, the compliance monitoring results demonstrate strong operational readiness, consistent adherence to key federal and State requirements, and an effective corrective action and oversight framework that supports continued compliance improvement across the Nebraska Medicaid Heritage Health program.

MLTC's requirement for quarterly GeoAccess reporting, combined with MCO oversight of provider compliance with established wait time standards and corrective action processes, reflects a proactive and structured approach to monitoring and maintaining network adequacy.

Recommendations

The statewide performance for the Quality Strategy aims with applicable MY 2024 quality measures indicates that a limited number of measures met established targets across the four aims, suggesting opportunities for improvement.



Quality Strategy Aim 1 (Improve the Member Experience of Care) included eight applicable quality measures, all of which had established targets; however, only two measures met the target, resulting in a target achievement rate of 25 percent. HSAG recommends that MLTC collaborate with the MCOs to conduct targeted root cause analyses and implement evidence-based interventions to improve performance on underperforming measures. HSAG recommends that MLTC focus on one area for improvement that corresponds with the State's current managed care program priorities. Lower-performing measures that could benefit from quality improvement activities or initiatives include strengthening access to preventive services, enhancing outreach and member engagement, and improving care coordination for chronic conditions.



Quality Strategy Aim 2 (Improve the Provider Experience of Care) included two applicable measures, both with established targets, and one measure met the target, for a target achievement rate of 50 percent, the highest among the four aims. HSAG recommends that MLTC prioritize the development and implementation of standardized provider satisfaction measures and targets to enable future evaluation of provider experience. Establishing clear expectations and data collection processes for provider survey measures should strengthen oversight and support ongoing improvements in provider engagement and satisfaction.



Quality Strategy Aim 3 (Improve the Health of Populations) included the greatest number of applicable measures, with 33 measures reported and 33 measures with established targets. Of these, 13 measures achieved the target, resulting in a target achievement rate of 39 percent. HSAG recommends that MLTC enhance monitoring and accountability by requiring the MCOs to track initiation and engagement milestones and implement corrective actions when performance remains below targets.



Quality Strategy Aim 4 (Reduce the Per Capita Cost of Health Care) included four applicable measures, all with established targets, and one measure met the target, for a target achievement rate of 25 percent. HSAG recommends that MLTC strengthen expectations for care coordination and follow-up processes to ensure timely access to treatment after diagnosis and continued engagement in SUD treatment services.

Additionally, when MLTC reviews and updates the Quality Strategy, HSAG offers the following recommendations:

MLTC should review and refine the methodology used to establish statewide performance targets for each Quality Strategy objective to ensure that targets are directly comparable to the MY rates used for evaluation. Of note, during this evaluation, HSAG identified limitations in comparing certain MY 2024 performance results to statewide targets due to differences in data sources, calculation

methodologies, and validation processes. Specifically, HSAG did not calculate statewide weighted average rates for Core Set measures, and available data included a combination of independently audited and non-audited MCO-reported rates that could not be consistently validated for purposes of this report.

To improve comparability and transparency, HSAG recommends that MLTC:

- Ensure that statewide performance targets are based on data that are calculated using a consistent methodology aligned with how MY performance rates are derived and reported.
- Clearly define data sources and validation requirements for measures included in the Quality Strategy, particularly for Core Set measures.
- Consider standardizing the use of audited or validated data where feasible to support reliable statewide comparisons.
- Provide clear documentation of how statewide baselines and targets are calculated to support consistent interpretation by stakeholders and the EQRO.

Strengthening alignment between performance targets and reported rates will improve the accuracy of performance assessments and enhance MLTC's ability to evaluate progress toward Quality Strategy goals.

Furthermore, HSAG recommends that MLTC consider updating the Quality Strategy Nebraska Medicaid Goals Tracking Appendix annually. As performance measures are added or retired and targets change, it is important that the MCOs and stakeholders have current information on measures and performance goals.

Appendix A. Nebraska Medicaid Goals Tracking Table

Table A-1—Medicaid Goals Tracking Table

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
1. Improve the Member Experience of Care 	1. Expand access to high-quality services to meet the needs of diverse clients	Ensure timely access to primary and specialty care	EQRO NAV evaluation	To Be Determined	Not Available	Not Available	To Be Determined	Comparison to the statewide target is not applicable, as MY 2024 results are not available.
			CAHPS Survey— <i>Getting Care Quickly</i> Aggregated Question Response	71.96%	87.83%	86.16%	75%	Performance exceeded the statewide target, indicating strong performance.
			CAHPS Survey— <i>Getting Needed Care</i> Aggregated Question Response	79.17%	89.71%	86.78%	82%	Performance exceeded the statewide target, indicating strong performance.
	2. Improve coordination of care	Ensure appropriate follow-up after ED visits and hospitalizations through effective care coordination and case management	<i>Follow-Up After ED Visit for Mental Illness (FUM)</i> • 30-Day Follow-Up	60.30%	58.33%	59.02%	64%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Follow-Up After ED Visit for Mental Illness (FUM)</i> • 7-Day Follow-Up	39.35%	38.76%	39.82%	44%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Follow-Up After ED Visit for Substance Use (FUA)</i> • 30-Day Follow-Up	43.47%	39.56%	40.35%	46%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Follow-Up After ED Visit for Substance Use (FUA)</i> • 7-Day Follow-Up	28.41%	24.88%	26.23%	30%	Performance fell below the statewide target, indicating an opportunity for improvement.
			Ambulatory Care: ED Visits (AMB) *per 12,000 beneficiary months, per HEDIS, to include all age groups	591.37	568.69	Discontinued for MY 2024	585	Comparison to the statewide target is not applicable, as the measure was discontinued for MY 2024.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
	3. Increase member satisfaction	Engage and partner with enrollees to improve enrollee experience and outcomes and increase public awareness about services	CAHPS Survey— <i>Health Plan Customer Service</i> Aggregated Question Response	87.67%	89.27%	89.49%	90%	Performance fell below the statewide target, indicating opportunity for improvement.
			CAHPS Survey— <i>Rating of All Health Care</i> Aggregated Question Response	67.92%	64.96%	64.38%	71%	Performance fell below the statewide target, indicating an opportunity for improvement.
2. Improve the Provider Experience of Care 	4. Timely decision making	Ensure timely payment for claims	Claims Processing Timeliness Quality Performance Program (QPP): Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 10 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	98.42%	98.13%	98.40%	99%	Performance fell below the statewide target, indicating opportunity for improvement.
		Resolve appeals in a timely manner	Appeal Resolution Timeliness QPP: MCO must resolve each appeal, and provide notice, as expeditiously as the member’s health condition requires, within 45 calendar days from the day the MCO receives the appeal.	99.94%	99.94%	99.78%	Remain above 99%	Performance exceeded the statewide target, indicating strong performance.
	5. Increase provider satisfaction	Streamline provider credentialing by incorporating into Heritage Health contracts the requirement that all MCOs jointly procure a central credentialing verification subcontractor	Provider Survey	To Be Determined	Not Available	Not Available	To Be Determined	Comparison to the statewide target is not applicable, as MY 2024 results are not available.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
	6. Build transparent and trusting stakeholder relationships	Conduct regular “listening sessions” where relevant division leadership meet with provider and community constituents at least quarterly to solicit their ideas, suggestions, and feedback for incorporation into policies and program improvements when/where possible.	Provider Survey	To Be Determined	Not Available	Not Available	To Be Determined	Comparison to the statewide target is not applicable, as MY 2024 results are not available.
3. Improve the Health of Populations 	7. Promote wellness and prevention	Improve screening rates for cancers	<i>Breast Cancer Screening (BCS)</i>	56.46%	53.78%	61.62%	59%	Performance exceeded the statewide target, indicating strong performance.
			<i>Colorectal Cancer Screening (COL)</i>	38.76%	40.78%	50.39%	42%	Performance exceeded the statewide target, indicating strong performance.
			<i>Cervical Cancer Screening (CCS)</i>	55.88%	57.67%	56.26%	58%	Performance fell below the statewide target, indicating opportunity for improvement.
		Promote oral health	<i>Oral Evaluation, Dental Services (OEV-CH)</i>	45.87%	44.56%	46.40%	50%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Topical Fluoride for Children (TFL-CH)</i>	22.33%	22.87%	28.19%	25%	Performance exceeded the statewide target, indicating strong performance.
			<i>Sealant Receipt on Permanent First Molars (SFM-CH)</i>	59.66%	59.29%	63.05%	62%	Performance exceeded the statewide target, indicating strong performance.
			<i>Periodontal Evaluation in Adults with Periodontitis (PEV-A)</i>	40.70%	37.28%	41.18%	42%	Performance fell below the statewide target, indicating opportunity for improvement.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
		Ensure access to care during pregnancy, childbirth and postpartum	<i>Prenatal and Postpartum Care: Postpartum Care (PPC)</i>	72.75%	78.17%	82.49%	75%	Performance exceeded the statewide target, indicating strong performance.
			<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)</i> • MMEC—3 Days	1.80%	2.99%	1.46%	3%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Contraceptive Care—Postpartum Women—Ages 15 to 20 Years (CCP-CH)</i> • MMEC—90 Days	41.63%	47.76%	49.18%	44%	Performance exceeded the statewide target, indicating strong performance.
			<i>Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)</i> • LARC—3 Days	0.83%	1.87%	0.37%	2%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Contraceptive Care—Postpartum Women Ages 15 to 20 (CCP-CH)</i> • LARC—90 Days	20.75%	23.32%	23.22%	23%	Performance exceeded the statewide target, indicating strong performance.
			<i>Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)</i> • MMEC—3 Days	8.88%	9.12%	8.54%	10%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)</i> • MMEC—90 Days	38.69%	43.42%	44.49%	41%	Performance exceeded the statewide target, indicating strong performance.
			<i>Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)</i> • LARC—3 Days	0.89%	0.78%	0.78%	2%	Performance fell below the statewide target, indicating an opportunity for improvement.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
			<i>Contraceptive Care—Postpartum Women Ages 21 to 44 (CCP-AD)</i> • <i>LARC—90 Days</i>	14.02%	16.45%	16.73%	16%	Performance exceeded the statewide target, indicating strong performance.
		Promote healthy development and wellness in children and adolescents	<i>Well-Child Visits in the First 30 Months of Life (W30)</i>	66.70%	69.20%	68.63%	69%	Performance fell below the statewide target, indicating opportunity for improvement.
			<i>Child and Adolescent Well-Care Visits (WCV)</i>	46.84%	48.87%	52.27%	50%	Performance exceeded the statewide target, indicating strong performance.
			<i>Lead Screening in Children (LSC)</i>	70.27%	70.83%	74.33%	73%	Performance exceeded the statewide target, indicating strong performance.
		Improve immunization rates	<i>Immunizations for Adolescents (IMA) Combination 2</i>	31.86%	32.70%	33.12%	35%	Performance fell below the statewide target, indicating opportunity for improvement.
			<i>Childhood Immunization Status (CIS) Combination 10</i>	46.03%	43.71%	40.07%	50%	Performance fell below the statewide target, indicating an opportunity for improvement.
		Ensure appropriate use of prescription drugs	<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	64.94%	65.79%	59.91%	67%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Asthma Medication Ratio (AMR)</i>	69.34%	73.33%	71.01%	72%	Performance fell below the statewide target, indicating opportunity for improvement.
	8. Improve Chronic disease management and control	Improve hypertension, diabetes, and cardiovascular disease management and control	<i>Controlling High Blood Pressure (CBP-AD)</i>	71.97%	68.36%	61.74%	75%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Diabetes Short-Term Complications Admission Rate (PQI01) *per 100,000 beneficiary months</i>	14.23	17.52	20.76	14	Performance exceeded the statewide target, indicating an opportunity for improvement.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
		Improve access to mental health and SUD care	1115 SUD Metric #11—Withdrawal Management	1.02%	1.12%	1.17%	3%	Performance fell below the statewide target, indicating an opportunity for improvement.
			1115 SUD Metric #12—Medication Assisted Treatment	6.34%	7.03%	7.18%	8%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)</i> • <i>Initiation Phase</i>	45.61%	45.86%	47.48%	48%	Performance fell below the statewide target, indicating opportunity for improvement.
			<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)</i> • <i>Continuation and Maintenance Phase</i>	54.10%	52.00%	51.10%	57%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)</i> • <i>Blood Glucose</i>	50.94%	52.84%	53.66%	54%	Performance fell below the statewide target, indicating opportunity for improvement.
			<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)</i> • <i>Cholesterol</i>	31.42%	35.51%	35.40%	35%	Performance exceeded the statewide target, indicating strong performance.
			<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)</i> • <i>Blood Glucose Cholesterol</i>	29.16%	33.31%	33.89%	32%	Performance exceeded the statewide target, indicating strong performance.

Aim	Goal	Objective	Quality Measure	Statewide Performance Baseline	MY 2023	MY 2024	Statewide Performance Target for Objective	Evaluation (MY compared to Statewide Performance Target)
			<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)</i>	58.75%	59.65%	58.18%	60%	Performance fell below the statewide target, indicating opportunity for improvement.
4. Reduce the Per Capita Cost of Health Care 	9. Enhanced preventative care to prevent treatable conditions from becoming costly medical conditions	Reduce the number of ED visits SUDs.	1115 SUD Metric #23—ED Utilization for SUD per 1,000 Medicaid Beneficiaries	3.48	3.46	3.59	3	Performance exceeded the statewide target, indicating an opportunity for improvement.
		Increase the percentage of adults who initiate and continue treatment after a diagnosis of alcohol or other drug abuse/dependence.	<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)</i> • <i>Initiation of SUD Treatment</i>	37.63%	38.13%	37.66%	40%	Performance fell below the statewide target, indicating an opportunity for improvement.
			<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)</i> • <i>Engagement of SUD Treatment</i>	11.43%	11.04%	11.13%	14%	Performance fell below the statewide target, indicating an opportunity for improvement.
		Improve maternal health and reduce the pre-term birth rate in Medicaid beneficiaries.	<i>Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)</i>	74.33%	82.34%	88.35%	78%	Performance exceeded the statewide target, indicating strong performance.