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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2021–2022 External Quality Review Technical Report

for

Heritage Health Program

April 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Background

Introduction

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

Heritage Health Program

Heritage Health, Nebraska's Medicaid and CHIP managed care program, is administered by MLTC, a division within DHHS. The current MCE contracts are full-risk, capitated managed care contracts. Managed care to administer the Medicaid and CHIP programs in Nebraska was developed to improve the health and wellness of Nebraska's Medicaid and CHIP members by increasing access to comprehensive health care services in a cost-effective manner. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), DHHS contracts with three MCOs to provide physical and behavioral health care, and pharmacy services; and one dental PAHP to provide dental services for Nebraska's Medicaid and CHIP members. Notable features of Nebraska's Medicaid and CHIP programs include the integration of physical and behavioral health care for all 93 counties in the State of Nebraska. DHHS does not exempt any of its MCEs from external quality review.

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Aug 9, 2021.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Aug 9, 2021.

Table 1-1—Heritage Health MCEs

MCE	Services Provided
Healthy Blue (**HBN**)	Physical and behavioral health care, and pharmacy services
Nebraska Total Care (**NTC**)	Physical and behavioral health care, and pharmacy services
United Healthcare Community Plan (**UHCCP**)	Physical and behavioral health care, and pharmacy services
Managed Care of North America, Inc. (**MCNA**)	Dental services

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS protocols released in October 2019.[1-3] In contract year (CY) 2021–2022, HSAG conducted both mandatory and optional EQR-related activities. The mandatory activities conducted were:

- **Validation of performance improvement projects (PIPs) (Protocol 1).** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.
- **Validation of performance measures—HEDIS methodology (Protocol 2).** To assess the accuracy of the performance measures reported by or on behalf of the MCEs, each MCO's licensed HEDIS auditor validated each of the performance measures selected by DHHS for review. The HEDIS Compliance Audit also determined the extent to which performance measures calculated by the MCOs followed specifications required by NCQA. HSAG obtained each MCO's HEDIS data and final audit report (FAR) produced by the MCO's HEDIS auditor, and evaluated the data and report to ensure that the HEDIS audit activities were conducted as outlined in the current NCQA specifications.
- **Validation of performance measures—Dental PAHP (Protocol 2).** HSAG validated performance measures calculated by **MCNA** to assess the accuracy of performance measures reported by Nebraska's dental benefit manager (DBM). The validation also determined the extent to which performance measures calculated by the DBM followed specifications required by DHHS.
- **Assessment of compliance with Medicaid and CHIP managed care regulations (compliance with regulations) (Protocol 3).** Assessment of compliance with regulations was designed to determine the MCEs' compliance with their contracts with DHHS and with State and federal managed care regulations. HSAG determined compliance through review of 13 standard areas developed based on the Medicaid and CHIP managed care regulations and DHHS' contract with the MCEs.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 9, 2021.

HSAG conducted the following optional activity:

- **Validation of network adequacy (Protocol 4).** NAV activities in CY 2021–2022 were designed to establish a framework from which DHHS can build annual NAV activities that evaluate the accuracy of the MCEs' self-reported compliance with Heritage Health contract standards for access to care.

Reader's Guide

Report Purpose and Overview

To comply with federal health care regulations at 42 CFR Part 438, DHHS contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that HSAG conducted with Heritage Health MCEs throughout CY 2021–2022. This technical report is intended to help the Nebraska Heritage Health Program to:

- Identify areas for quality improvement
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the state's quality strategy, and the annual EQR activities
- Purchase high-value care
- Achieve a higher performance health care delivery system for Medicaid and CHIP beneficiaries
- Improve states' ability to oversee and mange MCEs they contract with for services
- Help MCEs improve their performance with respect to quality, timeliness, and access to care

How This Report Is Organized

Section 1—Executive Summary includes a brief introduction to the Medicaid and CHIP managed care regulations and the authority under which this report must be produced. It also describes Nebraska's Medicaid and CHIP managed care program as well as the scope of the EQR-related activities conducted during CY 2021–2022.

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

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

Managed Care Quality Strategy to better support the improvement of the quality and timeliness of, and access to health care provided by the MCEs.

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

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

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

Appendices A–D provide for each MCE an activity-specific presentation of results of the EQR-related activities and an assessment of the quality and timeliness of, and access to care and services as applicable to the activities performed and results obtained. These appendices also present activity-specific conclusions and recommendations based on CY 2021–2022 EQR-related activities, as well as follow-up on recommendations made based on the prior year's EQR-related activities. Additionally, a more in-depth explanation of the NCQA information system (IS) standards is provided in *Appendix E* of this report.

Definitions

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

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCE, PIHP, PAHP, or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through:
>
> - Its structural and operational characteristics.
> - The provision of services that are consistent with current professional, evidence-based knowledge.
> - Interventions for performance improvement.[1-4]

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations.* Title 42, Volume 81, May 6, 2016.

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-5] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of "timeliness" to include other managed care provisions that impact services to enrollees and that require timely response by the MCE—e.g., processing appeals and providing timely care.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[1-6]

[1-5] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCEs*.
[1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

2. Statewide Comparative Results

Validation of Performance Improvement Projects

Results

Table 2-1 summarizes CY 2021–2022 PIP performance for each MCE. Each MCE conducted a PIP focusing on a topic as directed by DHHS. Table 2-1 also presents the validation status.

Table 2-1—Statewide PIP Results for MCEs

MCE	PIP Topic	Overall Validation Status
HBN	*Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)*	*Met*
NTC	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*Met*
UHCCP	*Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications*	*Met*
MCNA	*Preventive Dental Service*	*Met*

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects

For MCEs statewide, the following conclusions were identified:

- For the CY 2021–2022 PIP validation, all four MCEs received a *Met* overall PIP validation status, demonstrating that the MCEs addressed all critical evaluation elements in the PIP submissions. **[Quality]**
- All four MCEs had progressed to reporting remeasurement results for the PIP performance indicators; therefore, the PIP validation included evaluation of all three PIP stages—Design, Implementation, and Outcomes. **[Quality]**
- All four MCEs received *Met* scores for 100 percent of evaluation elements in the Design stage, suggesting that the PIP designs were methodologically sound, enabling each MCE to accurately collect data and evaluate progress on improving outcomes aligned with the PIP topic. **[Quality]**

For MCEs statewide, the following opportunities for improvement were identified:

- In the Implementation stage, two MCEs, **UHCCP** and **MCNA**, received *Met* scores for 100 percent of evaluation elements, demonstrating that these MCEs addressed all requirements for analyzing remeasurement results and carrying out improvement strategies for the PIPs. The remaining two MCEs, **HBN** and **NTC**, addressed all improvement strategy requirements but had opportunities for improvement pertaining to the methods used for analyzing and interpreting performance indicator results. HSAG recommended that **HBN** and **NTC** ensure that statistical testing is accurately conducted and reported to compare annual performance indicator remeasurement results to baseline results and identify whether any demonstrated improvement was statistically significant. HSAG recommended that the MCEs seek technical assistance, as needed, to ensure that complete and accurate statistical testing results are reported in the PIP submissions. **[Quality]**
- In the Outcomes stage, all four MCEs had opportunities for improvement. The three MCOs, **HBN**, **NTC**, and **UHCCP**, reported performance indicator results from the first annual remeasurement period for this year's validation. The DBM, **MCNA**, reported performance indicator results from the second annual remeasurement period for this year's validation. The MCOs' reported results from the first remeasurement period did not demonstrate statistically significant improvement over baseline performance. While the results reported by **UHCCP** demonstrated an improvement over baseline, the improvement was not statistically significant; the results reported by **HBN** and **NTC** demonstrated declines in performance from baseline to the first remeasurement. While **MCNA**'s reported remeasurement results demonstrated statistically significant improvement over baseline at the first remeasurement for three of four performance indicators, the results of the second remeasurement did not demonstrate sustained improvement among those three indicators, and the fourth performance indicator did not demonstrate statistically significant improvement over baseline at either the first or second remeasurement. **[Quality, Timeliness, and Access]**

To facilitate meaningful improvement of performance indicator results and support improved PIP performance in the Outcomes stage for MCEs statewide, the following recommendations were identified:

- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The MCEs should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced. **[Quality, Timeliness, and Access]**
- Revisit causal/barrier analyses at least annually to ensure that the identified barriers and opportunities for improvement are still applicable. **[Quality, Timeliness, and Access]**
- Use quality improvement (QI) tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses as part of the causal/barrier analyses. **[Quality, Timeliness, and Access]**

Validation of Performance Measures—MCOs

Results for Information Systems Standards Review

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

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

In accordance with NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that the MCOs' IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. The MCOs may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

The section that follows provides a summary of the MCOs' key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in Appendix E of this report.

Table 2-2—Summary of Compliance With IS Standards

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used.	All MCOs were compliant with IS Standard 1.0 for medical services data capture and processing. All MCOs only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
• Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored.	
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCOs continually assess data completeness and take steps to improve performance. • The MCOs effectively monitor the quality and accuracy of electronic submissions. • The MCOs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	All MCOs were compliant with IS Standard 2.0 for enrollment data capture and processing. The MCOs had policies and procedures in place for submitting electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	All MCOs were compliant with IS Standard 3.0 for practitioner data capture and processing. The MCOs appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, the MCOs reviewed all provider data received from delegated entities.
IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed.	All MCOs were compliant with IS Standard 4.0 for medical record review (MRR) processes. Data collection tools used by the MCOs were able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
• Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for electronic clinical data system (ECDS) reporting met reporting requirements. • NCQA-certified eCQM (electronic clinical quality measure) data met reporting requirements.	All MCOs were compliant with IS Standard 5.0 for supplemental data capture and processing. The HEDIS repositories contained all data fields required for HEDIS reporting. In addition, the appropriate quality processes for the data sources were reviewed and determined if primary source verification (PSV) was needed on all supplemental data that were in nonstandard form.
IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	All MCOs were compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by the MCOs' staff members. Data were verified for accuracy at each data merge point.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	All MCOs were compliant with IS Standard 7.0 for data integration. The MCOs used an NCQA Certified Measures vendor for data production and rate calculation.

Results for Performance Measures

Table 2-3—Nebraska MCO Performance—CMS Adult and Child Core Set Measurement Year (MY) 2020

Performance Measures	HBN	NTC	UHCCP
CMS Adult Core Set Measures*			
AMM-AD: Antidepressant Medication Management[1]			
AMR-AD: Asthma Medication Ratio: Ages 19–64[1]			
BCS-AD: Breast Cancer Screening[1]			
CBP-AD: Controlling High Blood Pressure[1]			
CCP-AD: Contraceptive Care—Postpartum Women Ages 21–44[3]			
CCS-AD: Cervical Cancer Screening[1]			
CCW-AD: Contraceptive Care—All Women Ages 21–44[3]			
CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older[3]			
CHL-AD: Chlamydia Screening in Women Ages 21–24[1]			
COB-AD: Concurrent Use of Opioids and Benzodiazepines[3]			
CPA-AD: CAHPS Health Plan Survey 5.1H, Adult Version (Medicaid)			
FUA-AD: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence[1]			
FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older[1]			
FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness[1]			
FVA-AD: Flu Vaccinations for Adults Ages 18 to 64[3]			

Performance Measures	HBN	NTC	UHCCP
HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)[1]			
HPCMI-AD: Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HBA1c) Poor Control (>9.0%)[3]			
HVL-AD: HIV Viral Load Suppression[3]			
IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment[1]			
MSC-AD: Medical Assistance with Smoking and Tobacco Use Cessation[3]			
NCIDDS-AD: National Core Indicators Survey[2]			
OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer[3]			
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder	NR	33.20%	51.75%
PC01-AD: PC-01: Elective Delivery[2]			
PCR-AD: Plan All-Cause Readmissions[1]			
PPC-AD: Prenatal and Postpartum Care: Postpartum Care[1]			
PQI01-AD: PQI 01: Diabetes Short-Term Complications Admission Rate[3]			
PQI05-AD: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate[3]			
PQI08-AD: PQI 08: Heart Failure Admission Rate[3]			
PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,00 Member Months)	NR	2.72	1.73
SAA-AD: Adherence to Antipsychotic Medications for Individuals with Schizophrenia[1]			
SSD-AD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]			
CMS Child Core Set Measure*			
ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication[1]			
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits			
*Age <1^*	58.28	31.32	52.75
*Ages 1 to 9^*	23.93	25.36	22.27
*Ages 10 to 19^*	20.95	24.15	20.89
*Total^*	NR	NR	23.49
AMR-CH: Asthma Medication Ratio: Ages 5–18[1]			
APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotic[3]			

Performance Measures	HBN	NTC	UHCCP
APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[3]			
AUD-CH: Audiological Diagnosis No Later than 3 Months of Age	NR	0.00%	NR
CCP-CH: Contraceptive Care—Postpartum Women Ages 15–20[3]			
CCW-CH: Contraceptive Care—All Women Ages 15–20[3]			
CDF-CH: Screening for Depression and Follow-Up Plan: Ages 12–17	NR	0.42%	0.42%
CHL-CH: Chlamydia Screening in Women Ages 16–20[1]			
CIS-CH: Childhood Immunization Status[1]			
CPC-CH: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H—Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items[3]			
DEV-CH: Developmental Screening in the First Three Years of Life[3]			
FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17[1]			
IMA-CH: Immunizations for Adolescents[1]			
LBW-CH: Live Births Weighing Less Than 2,500 Grams[2]			
LRCD-CH: Low-Risk Cesarean Delivery[2]			
PDENT-CH: Percentage of Eligibles Who Received Preventive Dental Services[2]			
PPC-CH: Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]			
SFM-CH: Sealant Receipt on Permanent First Molar[2]			
W30-CH: Well-Child Visits in the First 30 Months of Life[1]			
WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents[1]			
WCV-CH: Child and Adolescent Well-Care Visits[3]			

Gray-shaded measures and reporting methodologies in the table above are not being displayed within this table due to one of the three reasons listed in the following table notes.

[1] CMS Adult Core Set and Child Core Set measures that were reported in HEDIS will be displayed as a HEDIS measure only within this report.

[2] DHHS noted on August 13, 2021, that some measures were not required for reporting.

[3] The measure rate not displayed may have not been selected by DHHS based on the revised measure list feedback from August 13, 2021, and none of the three MCOs reported measures not selected by DHHS for CMS Core Measure reporting.

* The MCO's self-reported CMS Adult Core Set and Child Core Set measures were not audited, and rates are presented for information only.

^ Rate is reported per 1,000 member months rather than a percentage.

NR indicates that the rate was not reported by the MCO.

Table 2-4—Nebraska MCO Performance and Statewide Weighted Averages—HEDIS MY 2020

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
HEDIS Measures—Effectiveness of Care: Prevention and Screening				
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile—Total	67.40% ★★	64.39% ★★	75.43% ★★★	69.22%
Counseling for Nutrition—Total	68.61% ★★★	56.34% ★★	69.59% ★★★	64.95%
Counseling for Physical Activity—Total	64.48% ★★★	60.00% ★★★	65.69% ★★★	63.44%
CIS: Childhood Immunization Status				
Combination 2	72.75% ★★★★	71.53% ★★★★	80.78% ★★★★★	74.74%
Combination 3	70.80% ★★★★	69.10% ★★★★	78.59% ★★★★★	72.56%
Combination 10	47.69% ★★★★★	49.64% ★★★★★	54.74% ★★★★★	50.44%
IMA: Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	75.18% ★★★	74.94% ★★	82.24% ★★★★	77.61%
LSC: Lead Screening in Children				
Lead Screening in Children	72.26% ★★★★	69.97% ★★★	73.97% ★★★★	72.01%
BCS: Breast Cancer Screening				
Breast Cancer Screening	40.62% ★	47.94% ★★	63.77% ★★★★★	53.06%
CCS: Cervical Cancer Screening				
Cervical Cancer Screening	63.99% ★★★★★	63.16% ★★★★	60.83% ★★★★	62.61%
CHL: Chlamydia Screening in Women				
Ages 16 to 20 Years	29.24% ★	26.96% ★	29.01% ★	28.33%
Ages 21 to 24 Years	40.39% ★	42.01% ★	39.96% ★	40.85%
Total	32.97% ★	32.17% ★	32.71% ★	32.59%

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
HEDIS Measures—Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Children with Pharyngitis				
Ages 3 to 17	73.83% ★★	71.04% ★	72.77% ★★	72.51%
Ages 18 to 64	63.57% ★★★	63.24% ★★★	59.87% ★★★	62.19%
Ages 65 and Older	NA	NA	NA	69.44%
Total	72.20% ★★★	69.77% ★★★	70.77% ★★★	70.86%
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.30% ★★	16.67% ★	26.12% ★★★★	22.11%
PCE: Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	34.02% ★	75.82% ★★★★★	67.07% ★★★	57.79%
Bronchodilator	43.44% ★	89.54% ★★★★★	84.15% ★★★	71.59%
AMR: Asthma Medication Ratio				
Ages 5 to 11	72.64% ★★	81.51% ★★★★	79.72% ★★★★	78.55%
Ages 12 to 18	58.84% ★	73.47% ★★★★	73.62% ★★★★★	70.41%
Ages 19 to 50	55.49% ★★★	65.84% ★★★★★	69.11% ★★★★★	65.18%
Ages 51 to 64	59.46% ★★★★	63.51% ★★★★★	68.64% ★★★★★	65.50%
Total	63.42% ★★★	73.71% ★★★★★	74.05% ★★★★★	71.58%
HEDIS Measures—Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure				
Controlling High Blood Pressure	52.80% ★★★	63.75% ★★★★★	68.37% ★★★★★	62.39%
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack				

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	70.97%
SPC: Statin Therapy for Patients With Cardiovascular Disease[2]				
CRE: Cardiac Rehabilitation[2]				
HEDIS Measures—Effectiveness of Care: Diabetes				
CDC: Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	84.91% ★★★★	85.40% ★★★★	92.21% ★★★★★	88.17%
*HbA1c Poor Control (>9.0%)**	45.74% ★★★	44.28% ★★★	29.68% ★★★★★	38.48%
HbA1c Control (<8.0%)	45.01% ★★★	47.20% ★★★★	59.12% ★★★★★	51.62%
Eye Exam (Retinal) Performed	52.07% ★★★★	57.18% ★★★★	69.34% ★★★★★	60.77%
Blood Pressure Control (<140/90 mm Hg)	63.02% ★★★★	63.02% ★★★★	71.78% ★★★★★	66.78%
KED: Kidney Health Evaluation for Patients With Diabetes[2]				
SPD: Statin Therapy for Patients With Diabetes[2]				
HEDIS Measures—Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management				
Effective Acute Phase Treatment	52.99% ★★★	52.05% ★★	63.93% ★★★★★	56.75%
Effective Continuation Phase Treatment	40.25% ★★★	39.41% ★★★	48.67% ★★★★★	43.11%
ADD: Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	44.11% ★★★	46.33% ★★★★	45.64% ★★★★	45.48%
Continuation and Maintenance Phase	56.72% ★★★★	61.05% ★★★★	55.30% ★★★	57.67%
FUH: Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17	55.00% ★★★★	48.11% ★★★	56.88% ★★★★	53.07%
30-Day Follow-Up—Ages 6 to 17	75.00% ★★★★	71.64% ★★★	78.90% ★★★★★	75.08%

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
7-Day Follow-Up—Ages 18 to 64	34.57% ★★★★	35.24% ★★★★	44.43% ★★★★★	38.18%
30-Day Follow-Up—Ages 18 to 64	54.26% ★★★★	55.87% ★★★★	66.41% ★★★★★	58.98%
7-Day Follow-Up—Ages 65 and Older	NA	NA	NA	26.47%
30-Day Follow-Up—Ages 65 and Older	NA	NA	NA	52.94%
7-Day Follow-Up—Total	42.19% ★★★★	40.52% ★★★★	49.31% ★★★★★	44.02%
30-Day Follow-Up—Total	62.17% ★★★★	62.45% ★★★★	71.24% ★★★★★	65.37%
FUM: Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	41.79% ★★★★	48.36% ★★★★	45.40% ★★★★	45.36%
30-Day Follow-Up—Total	61.59% ★★★★	65.37% ★★★★★	66.00% ★★★★★	64.48%
FUI: Follow-Up After High Intensity Care for Substance Use Disorder				
7-Day Follow-Up—Total	27.43% ★★★	28.31% ★★★	13.08% ★	23.78%
30-Day Follow-Up—Total	42.29% ★★★	45.18% ★★★	30.00% ★★	39.92%
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence				
7-Day Follow-Up—Total	11.04% ★★★	8.21% ★★★	8.30% ★★★	9.16%
30-Day Follow-Up—Total	14.05% ★★★	13.37% ★★★	12.46% ★★★	13.30%
POD: Pharmacotherapy for Opioid Use Disorder[2]				
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.25% ★★	80.29% ★★★★★	81.33% ★★★★★	79.20%
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People with Diabetes and Schizophrenia	53.19% ★	70.20% ★★★★	68.67% ★★★★	65.46%

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	73.53% ★★★★	72.22%
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.61% ★★★	71.11% ★★★★★	81.13% ★★★★★	74.47%
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics[2]				
HEDIS Measures—Effectiveness of Care: Overuse/Appropriateness				
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.31% ★★★★	0.70% ★★★	0.51% ★★★★	0.52%
PSA: Non-Recommended PSA-Based Screening in Older Men[3]				
URI: Appropriate Treatment for Children With URI				
Ages 3 Months to 17 Years	88.71% ★★	87.51% ★★	88.28% ★★	88.17%
Ages 18 to 64 Years	77.84% ★★★	76.08% ★★★	78.08% ★★★	77.31%
Ages 65 Years and Older	94.32% ★★★★★	NA	67.50% ★★★	80.10%
Total	87.51% ★★★	85.98% ★★	86.81% ★★★	86.76%
AAB: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis[2]				
LBP: Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	76.84% ★★★★	76.94% ★★★★	77.29% ★★★★	77.02%
HDO: Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	4.75% ★★★★	5.59% ★★★	7.23% ★★★	6.15%
UOP: Use of Opioids From Multiple Providers[2]				
COU: Risk of Continued Opioid Use[2]				

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
HEDIS Measures—Effectiveness of Care: Measures Collected Through Medicare Health Outcome Survey				
FVA: Flu Vaccinations for Adults Ages 18–64[1]				
FVO: Flu Vaccinations for Adults Ages 65 and Older[1]				
MSC: Medical Assistance With Smoking and Tobacco Use Cessation[1]				
PNU: Pneumococcal Vaccination Status of Older Adults[1]				
HEDIS Measures—Access/Availability of Care				
AAP: Adults' Access to Preventive/Ambulatory Health Services[2]				
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Ages 13 to 17	59.51% ★★★★★	34.07% ★	33.18% ★	41.26%
Engagement of AOD Treatment—Total—Ages 13 to 17	25.37% ★★★★★	17.22% ★★★★	15.91% ★★★★	19.20%
Initiation of AOD Treatment—Total—Ages 18 and Older	54.16% ★★★★★	38.40% ★★	34.66% ★	42.61%
Engagement of AOD Treatment—Total—Ages 18 and Older	16.43% ★★★★	9.25% ★★	8.23% ★★	11.39%
Initiation of AOD—Total—Total	54.88% ★★★★★	37.64% ★★	34.44% ★	42.40%
Engagement of AOD—Total—Total	17.62% ★★★★	10.64% ★★★	9.38% ★★★	12.58%
PPC: Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.32% ★★★	76.89% ★★	80.05% ★★★	78.70%
Postpartum Care	77.13% ★★★★	73.24% ★★★	78.10% ★★★★	76.08%
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
HEDIS Measures—Utilization				
W30: Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.95% ★★★★★	59.60% ★★★★	61.89% ★★★★★	61.52%

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	72.67% ★★★★	68.47% ★★★	70.35% ★★★	70.68%
WCV: Child and Adolescent Well-Care Visits[2]				
FSP: Frequency of Selected Procedures				
*Bariatric Weight Loss Surgery—0–19 Years—Male^*	0.00 NC	0.00 NC	0.00 NC	0.00
*Bariatric Weight Loss Surgery—20–44 Years—Male^*	0.00 NC	0.03 NC	0.02 NC	0.02
*Bariatric Weight Loss Surgery—45–64 Years—Male^*	0.00 NC	0.00 NC	0.10 NC	0.04
*Bariatric Weight Loss Surgery—0–19 Years—Female^*	0.00 NC	0.01 NC	0.00 NC	0.00
*Bariatric Weight Loss Surgery—20–44 Years—Female^*	0.09 NC	0.11 NC	0.12 NC	0.11
*Bariatric Weight Loss Surgery—45–64 Years—Female^*	0.20 NC	0.21 NC	0.11 NC	0.17
*Tonsillectomy—0–9 Years—Total^*	0.60 NC	0.62 NC	0.60 NC	0.61
*Tonsillectomy—10–19 Years—Total^*	0.26 NC	0.36 NC	0.29 NC	0.30
*Hysterectomy, Abdominal—15–44 Years—Female^*	0.10 NC	0.07 NC	0.06 NC	0.08
*Hysterectomy, Abdominal—45–64 Years—Female^*	0.14 NC	0.21 NC	0.06 NC	0.13
*Hysterectomy, Vaginal—15–44 Years—Female^*	0.17 NC	0.16 NC	0.21 NC	0.18
*Hysterectomy, Vaginal—45–64 Years—Female^*	0.17 NC	0.18 NC	0.09 NC	0.14
*Cholecystectomy, Open—30–64 Years—Male^*	0.00 NC	0.05 NC	0.02 NC	0.02
*Cholecystectomy, Open—15–44 Years—Female^*	0.01 NC	0.01 NC	0.01 NC	0.01
*Cholecystectomy, Open—45–64 Years—Female^*	0.03 NC	0.03 NC	0.09 NC	0.05
*Cholecystectomy, Laparoscopic—30–64 Years—Male^*	0.34 NC	0.38 NC	0.35 NC	0.35

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
Cholecystectomy, Laparoscopic—15–44 Years—Female^	0.76 NC	0.73 NC	0.81 NC	0.77
Cholecystectomy, Laparoscopic—45–64 Years—Female^	0.51 NC	0.79 NC	0.88 NC	0.74
Back Surgery—20–44 Years—Male^	0.46 NC	0.38 NC	0.46 NC	0.43
Back Surgery—45–64 Years—Male^	0.80 NC	0.84 NC	1.21 NC	0.97
Back Surgery—20–44 Years—Female^	0.20 NC	0.21 NC	0.16 NC	0.19
Back Surgery—45–64 Years—Female^	1.06 NC	0.82 NC	0.84 NC	0.90
Mastectomy—15–44 Years—Female^	0.05 NC	0.08 NC	0.08 NC	0.07
Mastectomy—45–64 Years—Female^	0.31 NC	0.43 NC	0.17 NC	0.29
Lumpectomy—15–44 Years—Female^	0.11 NC	0.08 NC	0.10 NC	0.10
Lumpectomy—45–64 Years—Female^	0.40 NC	0.58 NC	0.19 NC	0.37
AMB: Ambulatory Care				
Emergency Department Visits—Total^,*	36.29 ★★★★	40.37 ★★★★	37.07 ★★★★	37.86
Outpatient Visits—Total^	293.10 NC	314.72 NC	326.46 NC	311.35
IPU: Inpatient Utilization—General Hospital/Acute Care—Total				
Discharges per 1,000 Member Months—Total Inpatient—Total—All Ages^	7.82 NC	6.90 NC	6.04 NC	6.92
Average Length of Stay—Total Inpatient—Total—All Ages	4.60 NC	4.59 NC	5.22 NC	4.78
Discharges per 1,000 Member Months—Maternity—Total—All Ages^	5.52 NC	5.73 NC	4.38 NC	5.19
Average Length of Stay—Maternity—Total—All Ages	2.41 NC	2.53 NC	2.36 NC	2.44
Discharges per 1,000 Member Months—Surgery—Total—All Ages^	1.28 NC	1.16 NC	1.13 NC	1.19

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
Average Length of Stay—Surgery—Total—All Ages	9.00 NC	10.21 NC	10.22 NC	9.77
Discharges per 1,000 Member Months—Medicine—Total—All Ages^	3.66 NC	2.45 NC	2.38 NC	2.84
Average Length of Stay—Medicine—Total—All Ages	4.77 NC	4.68 NC	5.89 NC	5.07
IAD: Identification of Alcohol and Other Drug Services[2]				
MPT: Mental Health Utilization[2]				
ABX: Antibiotic Utilization[2]				
HEDIS Measures—Risk-Adjusted Utilization				
PCR: Plan All-Cause Readmissions				
*Observed Readmissions—Total**	10.51% ★★★	11.66% ★★	8.34% ★★★★★	10.40%
*Expected Readmissions—Total**	11.27% NC	10.86% NC	11.16% NC	11.09%
*O/E Ratio—Total**	0.93 NC	1.07 NC	0.75 NC	0.94
HEDIS Measures—Effectiveness of Care: Measures Collected Through Medicare Health Outcome Survey				
BCS-E: Breast Cancer Screening				
Breast Cancer Screening	—	—	63.50% NC	63.50%
ADD-E: Follow-Up Care for Children Prescribed ADHD Medication[2]				
DSF-E: Depression Screening and Follow-Up for Adolescents and Adults[2]				
DMS-E: Utilization of the Patient Health Questionnaire (PHQ)-9 to Monitor Depression Symptoms for Adolescents and Adults[2]				
DRR-E: Depression Remission or Response for Adolescents and Adults[2]				
ASF-E: Unhealthy Alcohol Use Screening and Follow-Up[2]				
AIS-E: Adult Immunization Status[2]				
PRS-E: Prenatal Immunization Status[2]				

Performance Measures	HBN	NTC	UHCCP	MCO Weighted Average
PND-E: Prenatal Depression Screening and Follow-Up[2]				
PDS-E: Postpartum Depression Screening and Follow-Up[2]				

Gray-shaded measures and reporting methodologies in the table above are not being displayed within the report due to one of the three reasons listed in the following table notes.

[1] HSAG was not able to display the CAHPS measure rates since they are not part of the Interactive Data Submission System (IDSS) received from the MCOs.

[2] DHHS did not select this measure to be displayed in the report based on the revised measure list feedback from August 13, 2021.

[3] This measure was not able to be reported since there is no Medicaid line of business as part of the specifications.

— indicates that the rate is not presented in this report as the measure was not reported by the MCOs.

NC indicates that a comparison to the HEDIS MY 2020 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MCOs followed the specifications, but the denominator was too small (<30) to report a valid rate.

* For this indicator, a lower rate indicates better performance.

^ Rate is reported per 1,000 member months rather than a percentage.

HEDIS MY 2020 Performance Levels represent the following percentile comparisons:

★★★★★ = *75th percentile and above*

★★★★ = *50th to 74th percentile*

★★★ = *25th to 49th percentile*

★★ = *10th to 24th percentile*

★ = *Below 10th percentile*

Table 2-5—Nebraska DBM Performance—HEDIS MY 2020

Performance Measures	MCNA
DBM Measures Only	
Preventive Dental Services	
Pdent: Preventive Dental Services	49.08%
Annual Dental Visit	
ADV: Annual Dental Visit members 2–3 years of age	43.48%
ADV: Annual Dental Visit members 4–6 years of age	61.64%
ADV: Annual Dental Visit members 7–10 years of age	65.25%
ADV: Annual Dental Visit members 11–14 years of age	59.62%
ADV: Annual Dental Visit members 15–18 years of age	51.13%
ADV: Annual Dental Visit members 19–20 years of age	37.71%
ADV: Annual Dental Visit members 2–20 years of age	57.03%

Performance Measures	MCNA
Utilization of Services, Dental Services	
UTL-CH-A: Utilization of Services; Dental Services	50.38%
Treatment Services, Dental Services	
TRT-CH-A: Treatment Services; Dental Services	16.36%
Oral Evaluation, Dental Services	
OEV-CH-A: Oral Evaluation; Dental Services	46.92%
Care Continuity, Dental Services	
CCN-CH-A: Care Continuity; Dental Services	40.77%

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Performance Measure Rates and Validation

HEDIS Statewide Conclusions, Opportunities for Improvement, and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10*, and *Cervical Cancer Screening* measure indicators were a strength for all three MCOs. All three MCOs for these measure indicators ranked at or above NCQA's Health Maintenance Organization (HMO) Quality Compass HEDIS MY 2020 50th percentile benchmark. The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* rates demonstrate that children 2 years of age are receiving immunizations for disease prevention to help protect them against a potential life-threatening illness and the spread of preventable diseases at a time in their lives when they are vulnerable.[2-1,2-2] In addition, the *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 were receiving screening for one of the most common causes of cancer death in the United States. The effective screening and early detection of cervical cancer have helped reduce the death rate in this country.[2-3] **[Quality, Timeliness, and Access]**

The *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for all three MCOs. All three MCOs for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. Untreated

[2-1] Mayo Clinic. 2014. "Infant and Toddler Health Childhood Vaccines: Tough questions, straight answers. Do vaccines cause autism? Is it OK to skip certain vaccines? Get the facts on these and other common questions." Available at: http://www.mayoclinic.com/health/vaccines/CC00014. Accessed on: Oct 28, 2021.

[2-2] Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief.

[2-3] American Cancer Society. 2020. "Key Statistics for Cervical Cancer." Last modified January 12, 2021. Available at: https://www.cancer.org/cancer/cervicalcancer/about/key-statistics.html. Accessed on: Oct 28, 2021.

chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility, and increased risk of becoming infected with human immunodeficiency virus-1 (HIV-1). Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[2-4] HSAG recommended that DHHS determine if the MCOs are following up annually with sexually active members through any type of communication to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the coronavirus disease 2019 (COVID-19) public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 51 to 64* measure indicator was a strength for all three MCOs. All three MCOs for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. Asthma is a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs for all stakeholders involved.[2-5] **[Quality]**

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for all three MCOs. All three MCOs for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. HSAG recommended that DHHS conduct a root cause analysis for the *Appropriate Testing for Pharyngitis* measure indicator to determine why members are not being tested. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics.[2-6] If the low rate in members accessing these services is identified as related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for all three MCOs. All three MCOs for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. According to NCQA (as cited by the Centers for Disease Control and Prevention [CDC]), proper management is needed to control members' blood glucose levels, reduce risk of complications, and extend members' lives. Care providers can help members by prescribing and

[2-4] Meyers DS, Halvorson H, Luckhaupt S. 2007. "Screening for Chlamydial Infection: An Evidence Update for the U.S. Preventive Services Task Force." *Ann Intern Med* 147(2):135–42

[2-5] Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Oct 28, 2021.

[2-6] Centers for Disease Control and Prevention. 2013. "Strep Throat: All You Need to Know." Available at: http://www.cdc.gov/Features/strepthroat/. Accessed on: Oct 28, 2021.

instructing proper medication practices, dietary regimens, and proper lifestyle choices such as exercise and quitting smoking.[2-7] **[Quality]**

Effectiveness of Care: Behavioral Health Domain

The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64*, *30-Day Follow-Up—Ages 18 to 64*, *7-Day Follow-Up—Total*, *30-Day Follow-Up—Total;* along with *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators were a strength for all three MCOs. All three MCOs for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates MCOs were appropriately managing care for patients hospitalized or discharged after an emergency department (ED) visit for mental health issues, as they are vulnerable after release. Follow-up care by trained mental health clinicians is critical for successfully transitioning out of an inpatient setting as well as preventing readmissions. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Imaging Studies for Low Back Pain* measure was a strength for all three MCOs. All three MCOs for this measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates MCO members did not have an imaging study within 28 days of the diagnosis. Evidence has shown that unnecessary imaging for low back pain does not improve outcomes and exposes members to harmful radiation and unnecessary treatment.[2-8] **[Quality]**

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for all three MCOs. All three MCOs for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommended that DHHS conduct a root cause analysis to ensure MCOs are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[2-9] In addition, HSAG recommended that MCO providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17* measure indicator was a strength for all three

[2-7] Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services.

[2-8] National Committee for Quality Assurance. *Use of Imaging Studies for Low Back Pain*. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 15, 2021.

[2-9] National Committee for Quality Assurance. *Appropriate Treatment for Children with Upper Respiratory Infection*. Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-children-with-upper-respiratory-infection/. Accessed on: Oct 15, 2021.

MCOs. All three MCOs for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates that adolescents 13 to 17 years of age initiated treatment and had two or more additional AOD services or medication-assisted treatment (MAT) within 34 days of the initiation visit. **[Quality, Timeliness, and Access]**

Utilization Domain

Within the Utilization domain, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator was also a strength for all three MCOs. All three MCOs for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates children within the first 15 months of life were seen by a primary care physician (PCP) in order to help influence and assess the member's early development stages. **[Quality and Access]**

In addition, the *Ambulatory Care—Emergency Department Visits—Total* measure indicator was a strength for all three MCOs. All three MCOs for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark, suggesting appropriate utilization of services.

DBM Conclusions, Opportunities for Improvement, and Recommendations

MCNA demonstrated sound practices related to both the claims review process and the data integration and reporting process. **MCNA** indicated that 20 percent of claims were reviewed by a claims examiner or the claims team prior to a claim being processed in order to verify accuracy and completeness prior to adjudication. In addition, 5 percent of claims were audited monthly by the **MCNA** claims audit team to ensure the overall accuracy of post-adjudicated claims.

As part of measure reporting, **MCNA** denoted multiple levels of review performed by **MCNA**, which included reviews conducted by the Information Technology (IT), Business, and Compliance departments. By establishing multiple levels of review within various departments, **MCNA** was able to provide accurate rates, allowing multiple employees with different perspectives and knowledge to review the accuracy of the reported rates.

HSAG did not identify any opportunities for improvement related to the accuracy of **MCNA**'s performance measure data during the 2021 performance measure validation (PMV) review, other than the recommendations mentioned below.

It was noted by **MCNA** during the review that the MY 2020 rates declined due to the COVID-19 public health emergency, which caused provider practice closures for a period of time and reduced provider operating hours. Once provider practices reopened, **MCNA** noted that providers might have focused on patient triage in order to accommodate patients requiring urgent dental care, which placed general and preventive care as a secondary priority. In order to accommodate the potential backlog of patients during the continuation of the COVID-19 public health emergency, HSAG recommended that **MCNA** continue to work with its provider network to identify optimal office hours to ensure members can receive

preventive services, and also for **MCNA** to continue to monitor its rates over time to identify pandemic-rate impact, ensuring lower access to preventive care is not driven by a non-pandemic cause.

Assessment of Compliance With Medicaid Managed Care Regulations

In CY 2021–2022, HSAG reviewed 13 standards, which represented all standards (Part 438 Subpart D and QAPI) with which MCEs are required to comply pursuant to 42 CFR Part 438. To assist Nebraska's Medicaid and CHIP MCEs with understanding the Medicaid and CHIP managed care regulations released in May 2016, with revisions released in November 2020, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions. MCEs demonstrating less than 100 percent compliance must develop a corrective action plan (CAP) to address each requirement found to not exhibit full compliance.

Results

Table 2-6 displays the compliance results for each MCE as well as the statewide average scores for each standard area.

Table 2-6—Compliance With Regulations—Statewide Performance for MCEs

Standard Number and Title	HBN	NTC	UHCCP	MCNA	Statewide Average
Standard I—Enrollment and Disenrollment 42 CFR §438.3(d); 42 CFR §438.56	100%	100%	86%	100%	97%
Standard II—Member Rights and Confidentiality 42 CFR §438.100; 42 CFR §438.224; 42 CFR §422.128	83%	67%	100%	100%	88%
Standard III—Member Information 42 CFR §438.10	77%	86%	82%	85%	83%
Standard IV—Emergency and Poststabilization Services 42 CFR §438.114	100%	100%	100%	100%	100%
Standard V—Adequate Capacity and Availability of Services 42 CFR §438.206; 42 CFR §438.207	86%	100%	100%	100%	97%
Standard VI—Coordination and Continuity of Care 42 CFR §438.208	100%	100%	100%	100%	100%
Standard VII—Coverage and Authorization of Services 42 CFR §438.210; 42 CFR §438.404	84%	89%	89%	82%	86%

Standard Number and Title	HBN	NTC	UHCCP	MCNA	Statewide Average
Standard VIII—Provider Selection and Program Integrity 42 CFR §438.12; 42 CFR §438.102; 42 CFR §438.106; 42 CFR §438.214; 42 CFR §438.602(b); 42 CFR §438.608; 42 CFR §438.610	94%	100%	94%	100%	97%
Standard IX—Subcontractual Relationships and Delegation 42 CFR §438.230	100%	75%	100%	50%	81%
Standard X—Practice Guidelines 42 CFR §438.236	100%	100%	100%	100%	100%
Standard XI—Health Information Systems 42 CFR §438.242	100%	100%	100%	100%	100%
Standard XII—Quality Assessment and Performance Improvement 42 CFR §438.330	100%	100%	100%	100%	100%
Standard XIII—Grievance and Appeal System 42 CFR §438.228; 42 CFR §438.400– 42 CFR §438.424	77%	58%	92%	85%	78%
Total Scores*	**88%**	**87%**	**93%**	**91%**	**90%**

* The total scores are calculated by dividing the total number of met elements for all standards by the total number of applicable elements.

Table 2-7 presents the record review results for each MCE as well as the statewide average scores for each record review type.

Table 2-7—Record Review Statewide Performance for MCEs

Record Type	HBN	NTC	UHCCP	MCNA	Statewide Average
Grievances	93%	100%	100%	94%	97%
Appeals	100%	92%	100%	100%	98%
Denials	94%	90%	94%	82%	90%
Totals*	**96%**	**93%**	**98%**	**92%**	**95%**

* The total score was calculated by dividing the total number of met elements by the total number of applicable elements. See Table A-7, Table B-7, Table C-7, and Table D-4 for each MCE's results.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Compliance With Regulations

For MCEs statewide, the following conclusions were identified:

- All four MCEs received 100 percent compliance with five out of the 13 standards. **[Quality, Timeliness, and Access]**
- All four MCEs received 100 percent compliance with the Emergency and Poststabilization Services standard and defined emergency medical condition and emergency services in a manner consistent with the federal definition. **[Timeliness and Access]**
- All four MCEs received 100 percent compliance with the Practice Guidelines standard, indicating that each MCE reviewed and updated clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. Guidelines were disseminated to all providers, and upon request to members and potential members. **[Quality]**
- Each MCE demonstrated 100 percent compliance with the Health Information Systems standard. The MCEs provided detailed workflows regarding the health information system requirements and described comprehensive system and data validation processes. The systems collected provider claims, encounter, grievance, appeal, utilization, and disenrollment data. **[Quality and Access]**
- All four MCEs received 100 percent compliance with the QAPI standard and demonstrated detailed work plan evaluations, methods to monitor quality of care, analyze over- and underutilization, and ensure improved outcomes for members with special health care needs. **[Quality]**
- The MCEs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to their Medicaid members. MCE-specific strengths, opportunities for improvement, and recommendations are detailed in appendices A–D. **[Quality, Timeliness, and Access]**
- All MCEs are required to develop CAPs based on the CY 2021–2022 compliance review. **[Quality, Timeliness, and Access]**
- All MCEs demonstrated strengths and opportunities for improvement in the areas of quality, timeliness, and access. **[Quality, Timeliness, and Access]**

For MCEs statewide, the most frequent opportunities for improvement were the following:

- HSAG identified opportunities for improvement for each MCE within the Member Information standard. However, a statewide trend could not be identified across all MCEs for a particular requirement. **[Access]**

For MCEs statewide, the most common required actions assigned were the following:

- All four MCEs had required actions assigned to requirements in the Member Information, Coverage and Authorization of Services, and Grievance and Appeal System standards. **[Quality, Timeliness, and Access]**

- A trend was identified with two requirements in the Member Information standard—all four MCEs had required actions related to 42 CFR §438.10(c)(6) and 42 CFR §438.10(g)(2)(xi).
  - For 42 CFR §438.10(c)(6), the MCEs will need to develop a CAP to ensure that any information that is available electronically meets all requirements. **[Access]**
  - For 42 CFR §438.10(g)(2)(xi), the MCEs will need to develop a CAP to ensure that the member handbook provided to members following enrollment includes all information regarding the grievance, appeal, and fair hearing procedures and timelines. **[Access]**

Validation of Network Adequacy

In CY 2021–2022, HSAG conducted the following activities to establish a framework from which DHHS can annually evaluate the accuracy of MCEs' compliance with program and contract standards for access to care:

- Conducted a desk review of DHHS' existing network adequacy documentation, including the MCEs' network adequacy reports and provider data submission materials.
- Developed and administered a DHHS-approved questionnaire to collect network data structure information from each MCE.
- Assessed the completeness and validity of select fields critical to network adequacy evaluation from the MCEs' provider data submissions.

Results

Desk Review Findings

HSAG reviewed CMS regulations, DHHS regulations and contract provisions, and examples of network adequacy reports currently submitted quarterly by the MCEs. The review specifically focused on the system aspects that impact network adequacy (i.e., the data elements necessary to calculate travel time and distance and to construct accurate provider directories). The documentation submitted by DHHS demonstrated its creation of a regulatory and contractual environment that sets standards for access, defines necessary data elements, sets out formats for reporting, and currently requires quarterly network adequacy reports by the MCEs. The system seems adequate to form the basis for future validation of network adequacy, including requiring data sufficient to test the MCEs' construction of provider directories and independent travel time and distance studies.

The MCEs' network documentation and prior reports revealed that for the most part, they have developed systems capable of collecting the data elements necessary to meet regulatory and contractual requirements for identification of providers and construction of provider directories.

Data Structure Questionnaire Findings

HSAG distributed the DHHS-approved Data Structure Questionnaire to each MCE in July 2021 to request qualitative responses for 10 questionnaire elements together with supplemental documentation supporting responses (e.g., data dictionaries, layouts, or sample reports). All MCEs participated in the questionnaire process and responded to HSAG's email requests for clarification, although there was variation among the plans, as expected. Each MCE's questionnaire responses were self-reported, and HSAG did not verify the responses against additional data sources. Notable findings across all MCEs' questionnaire responses included the following:

- MCEs' questionnaire responses reflected a variety of operating platforms, claims payment systems, and systems for delegating management of selected services to outside entities (e.g., delegating vision services and data management to a third-party vendor).
- Each MCE relied on its contracted providers to self-report information such as provider type, provider specialty, taxonomy code(s), degree(s), and licenses and certifications. The MCEs listed a variety of methods by which they confirmed and validated the provider information.
- All MCEs reported maintaining data fields to readily identify provider types required by DHHS standards.
- All MCEs reported maintaining a data field to monitor whether providers served members with specific clinical conditions (e.g., HIV/AIDS).
- Two of three MCOs reported maintaining a data field to capture the number of members that a provider is willing to serve (i.e., the provider's panel capacity). The DBM reported that it did not maintain information regarding panel capacity for any of its providers.
- Each MCE reported the use of single case agreements (SCAs) and/or letters of agreement (LOAs) to contract some providers.
- All MCEs reported offering an online provider directory through which members could identify providers.

MCE Provider Network Data Findings

All MCEs participated in the provider data submission process and responded to HSAG's email requests for clarification and data resubmission as needed. Each MCE's provider data submissions were assessed across key metrics for data request fidelity, or the extent to which the data that HSAG requested were reported by the MCE (percentage of records for which the data element is present), the extent to which requested data were reported in the format requested (valid format), and the extent to which data were reported with results in the expected range (valid value). Upon analysis, most of the records contained the requested data, and where scores for valid format and valid value could be calculated, the MCE tracked the score for completeness, indicating that where data were generally submitted in the correct format and contained expected values. Table 2-8 presents a comparison of the MCEs' scores for completeness as a percentage of network records containing each data element.

Table 2-8—Percent of Records Present[1] for Each Requested Data Field by MCE

Data Field Name	Data Field Description	HBN	NTC	UHCCP	MCNA
BusName**	The provider's business name, if applicable	100.0	84.7	100.0	100.0
ProvFName***	The first name of an individual provider	100.0	100.0	95.2	100.0
ProvLName***	The last name of an individual provider	100.0	100.0	95.2	100.0
ProvID	A unique identification number assigned for a servicing or billing provider	100.0	82.6	100.0	100.0
NPI	National Provider Identifier, a Health Insurance Portability and Accountability Act (HIPAA) standard unique identifier assigned to each health care provider	100.0	100.0	99.8	100.0
Sex***	The provider's gender	95.2	99.9	93.3	100.0
ProvAddress1	The first street address line for each provider/business servicing address	100.0	100.0	100.0	100.0
ProvCity	The city of each provider/business servicing address	100.0	100.0	100.0	100.0
ProvState	The state abbreviation code for each provider/business servicing address	100.0	100.0	100.0	100.0
ProvZip	The five-digit ZIP or postal code for each provider/business servicing address	100.0	100.0	100.0	100.0
ProvCounty	The county in which the provider's/business's servicing address is located	87.1	99.8	100.0	100.0
Phone	The telephone number associated with the servicing address at which the provider serves Heritage Health members	100.0	94.7	100.0	100.0
New_Pt	Indicator identifying whether the provider accepts new patients	100.0	99.6	91.0	100.0
Panel_Capacity	The maximum number of Heritage Health members that the provider will accept	100.0	98.7	95.5	0.0
PCP_Flag	Indicator identifying if the provider is a PCP	100.0	99.6	99.9	100.0
Alt_LangSpoken***	Indicator identifying whether the provider speaks a non-English language, including American Sign Language (ASL)	100.0	100.0	98.1	0.0
Prim_Lang***	Text description of the provider's primary language spoken, including English	100.0	99.9	0.0	0.0
Addl_Lang***	Text description of the provider's additional language spoken	13.2	100.0	7.3	0.0
Spec_cd1	Primary specialty of the provider/business	100.0	100.0	92.8	100.0
Provtype1	Provider type	100.0	98.7	7.2	100.0
Taxonomy1	Primary provider taxonomy code of the provider/business—10-digit code	100.0	99.5	96.2	100.0

Data Field Name	Data Field Description	HBN	NTC	UHCCP	MCNA
Degree***	Degree or certification attained, if available (e.g., medical doctor [MD], registered nurse [RN], licensed professional counselor [LPC])	99.5	88.2	95.2	100.0
Start_Date	The provider's MCE contract start date	100.0	100.0	100.0	100.0
End_Date	The provider's MCE contract end date	0.0	0.5	0.0	1.8

[1] *Percent of Records Present* indicates that the MCE submitted a non-missing data value for the specified data field.
Percentages are based on the total submitted records unless specified below:
** Only facilities included in calculation
*** Only individual practitioners included in calculation

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Network Adequacy

For MCEs statewide, the following conclusions were identified:

- All four MCEs responded to a provider data structure questionnaire and supplied provider data files for HSAG's review and evaluation. The MCEs reported reasonably complete provider data and described internal data processing and monitoring systems that appeared to be adequate to support future NAV activities and analysis. **[Quality]**

For MCEs statewide, the following opportunities for improvement were identified:

- To enhance and/or more thoroughly document their provider data maintenance, vendor oversight, and use of single case agreements. **[Quality and Access]**
- To proactively evaluate their provider data for accuracy and make necessary updates. **[Quality and Access]**
- To validate certain fields against external data sources to ensure data quality. **[Quality]**

For MCEs statewide, the following recommendations were identified to evaluate and address potential MCE data quality concerns:

- DHHS could consider requesting documentation of:
  - MCEs' internal verification and oversight practices to ensure the accuracy of their provider data. **[Quality]**
  - MCEs' policies, procedures, and recent reports for monitoring provider data received from vendors, including information demonstrating how frequently provider data anomalies are identified and corrected. **[Quality]**
  - MCEs' use and oversight of SCAs or LOAs, to verify that the plans are not using SCAs or LOAs in lieu of providing robust networks of providers. **[Access]**

- DHHS could consider modifying MCE contracts to require quarterly validation of provider directories and submission of results in conjunction with the quarterly reports of GeoAccess and timely access data. A statewide methodology could be developed to ensure consistent application across all MCEs. **[Quality and Access]**
- HSAG recommended that DHHS conduct quality studies to validate the MCEs' provider data, such as telephone surveys or verification of MCEs' online provider directory information. These activities will confirm the extent to which the MCEs' provider data supplied to DHHS accurately reflect the information published for members' use in accessing services. **[Quality]**
- HSAG recommended that DHHS institute some or all of the following types of validation studies in future years:
  - Network adequacy analyses and/or validation: Assesses the extent to which members have sufficient access to providers and/or whether health plans are meeting network standards. **[Quality and Access]**
  - Secret shopper surveys: Mirror the real-time experience of a member seeking care. **[Timeliness and Access]**

Overall Statewide Conclusions, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluation of EQR activity findings from CY 2021–2022 to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to Nebraska's Medicaid and CHIP members. For each MCE reviewed, HSAG provided results, strengths, and a summary assessment of opportunities for improvement and recommendations based on the MCEs' individual performance, which can be found in appendices A–D of this report.

The Heritage Health program's MCEs are largely in compliance with federal and State managed care requirements. Overall, the MCEs are performing well. When deficiencies were identified, the MCEs responded with corrective actions, demonstrating their commitment to quality improvement. The CY 2021–2022 EQR activities provided evidence of the MCEs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Nebraska's Medicaid and CHIP members.

All MCEs demonstrated strengths, opportunities for improvement, and recommendations in the areas of quality, timeliness, and access. The MCEs should address specific recommendations identified to improve performance in these areas. Additionally, each MCE should continue to monitor performance and collaborate with DHHS to overcome any public health emergency barriers.

HSAG recommended that each MCE trend performance to gauge where it meets and exceeds requirements to identify opportunities for improvement. By implementing interventions and addressing opportunities for improvement and recommendations from each external quality review activity, the MCEs should demonstrate improvement in the areas of quality, timeliness, and access to care. Furthermore, all MCEs addressed most of their follow-up on the prior year's recommendations.

DHHS has effectively managed oversight and collaboratively worked with the MCEs and the EQRO to ensure successful program operations and monitoring of performance. HSAG recommended that DHHS continue to monitor, assess, and improve priority areas.

Nebraska's Managed Care Quality Strategy

The Heritage Health Program was designed to simplify the delivery model for Medicaid recipients by integrating physical health benefits and behavioral health benefits into a single health plan. MLTC's mission for Medicaid is to furnish medical assistance to disadvantaged and vulnerable individuals through improving population health, enhancing the member and provider experience, and ensuring the long-term financial viability of the Medicaid program. To provide a means for achieving this mission, the program developed a quality strategy for both Heritage Health and the Dental Benefit Program.

Goals and Objectives

The goals and objectives of the Heritage Health Program directly reflect the Quadruple Aim of improving member experience of care, provider experience, the health of populations, and reducing the per-capita cost of health care.

MLTC developed the following goals under the physical and behavioral health system:

- Improve health outcomes
- Enhance integration of services and quality of care
- Put emphasis on person-centered care, including enhanced preventive and case management (CM) services (focusing on the early identification of members who require active CM)
- Reduce rate of costly and avoidable care
- Improve financially sustainable system
- Increase evidence-based treatment
- Increase outcome-driven, community-based programming and support
- Increase coordination among service providers
- Promote a recovery-oriented system of care
- Expand access to high-quality services (including hospitals, physicians, specialists, pharmacies, mental health and substance use disorder [SUD] services, federally qualified and rural health centers, and allied health providers) to meet the needs of MLTC's diverse clients

In terms of oral health, MLTC seeks to achieve the following goals under the DBM:

- Improved access to routine and specialty dental care
- Improved coordination of care
- Better dental health outcomes

- Increased quality of dental care
- Outreach and education to promote dental health
- Increased personal responsibility and self-management
- Overall saving to the Nebraska Medicaid program by preventing treatable dental conditions from becoming costly medical conditions

MLTC evaluates progress in meeting these goals and objectives through:

- Performance improvement and measurement
- State standard compliance monitoring
- External quality review activities
- Interventions that MLTC is undertaking to improve quality of care to Medicaid managed care (MMC) members

Recommendations

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

- Encourage and support each MCE to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations.
- Continue to support, guide, and work collaboratively with each plan as they become compliant with requirements.
- Establish a workgroup to address common improvement opportunities surrounding grievance and appeal system compliance.
- Continue striving to improve member experience of care, provider experience, the health of populations, and reduce the per-capita cost of health care services.
- Require each MCE to complete CAPs identified by HSAG during the compliance monitoring review.
- By implementing recommendations and addressing opportunities for improvement, the MCEs will facilitate improvement in the areas of quality, timeliness, and access to care for Medicaid members.
- Continue to effectively manage the oversight and work collaboratively with each MCE and HSAG to ensure successful program operations and monitoring of performance.
- HSAG recommended that DHHS continue to monitor MCE performance and adjust goals to encourage a positive trend in performance.

3. Methodology

This section, requirement §438.364(a)(1), describes the manner in which (1) the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, access to the care furnished by each MCE.

Validation of Performance Improvement Projects

Objectives

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

The primary objective of PIP validation is to determine each MCE's compliance with requirements set forth in 42 CFR §438.240(b) (1), including:

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

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS' *EQR Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.[3-1]

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

1. HSAG evaluates the technical structure of the PIP to ensure that the MCE designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 11, 2021.

component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCE improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results). The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed (NA)*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all the critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. The outcome of these calculations determined the validation status of *Met*, *Partially Met*, or *Not Met*.

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

How Conclusions Were Drawn

Using a standardized scoring methodology, HSAG assigned an overall validation status and reported the overall validity and reliability of the findings as one of the following:

- ***Met*** = High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- ***Partially Met*** = Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- ***Not Met*** = Reported findings are not credible. All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

PIPs that accurately addressed CMS EQR protocol requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the study results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was not credible.

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

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

MCE	Performance Improvement Project	Quality	Timeliness	Access
HBN	*Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)*	✓	✓	✓
NTC	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	✓	✓	✓
UHCCP	*Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications*	✓	✓	✓
MCNA	*Preventive Dental Service*	✓	✓	✓

Validation of Performance Measures

Objectives

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

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

Technical Methods of Data Collection

MCOs

DHHS required that each MCO undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA- LO. CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019,[3-2] identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the FAR for each MCO and aggregated several sources of HEDIS-related data to confirm that the MCOs met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS Compliance Audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.*[3-3]

- Teleconference calls with the MCO's personnel and vendor representatives, as necessary.
- Detailed review of the MCO's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the MCO's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 10, 2021.

[3-3] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification (PSV).
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the determinations of the MCO's MRR contractor for the same records.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS MY 2020 rates as presented within the NCQA-published IDSS completed by the MCO and/or its contractor.

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

The DBM

DHHS selected the performance measures for calculation by the DBM, and the DBM completed the calculation of all measures by using a number of data sources, including claims/encounter data and enrollment/eligibility data.

HSAG conducted PMV for the DBM's measure rates. DHHS required that the MY 2020 (i.e., Jan 1, 2020–December 30, 2020) performance measures be validated during 2021 based on NCQA, CMS Child Core Set, and American Dental Association (ADA) specifications.

HSAG's process for PMV for the DBM included the following steps.

Pre-Review Activities: Based on the measure definitions and reporting guidelines provided by DHHS, HSAG:

- Developed measure-specific worksheets that were based on the measure specifications and were used to improve the efficiency of validation work performed during the virtual site review.
- Developed an Information Systems Capabilities Assessment Tool (ISCAT) that was used to collect the necessary background information on the DBM's IS, policies, processes, and data needed for the

virtual performance of validation activities. HSAG included questions to address how encounter data were collected, validated, and submitted to DHHS.

- Reviewed other documents in addition to the ISCAT, including source code for performance measure calculation and supporting documentation.
- Performed other pre-review activities including review of the ISCAT and supporting documentation, scheduling, and preparing the agenda for the virtual site visit, and conducting conference calls with the DBM to discuss the virtual review activities and to address any ISCAT-related questions.

Virtual Site Review Activities: HSAG conducted a virtual site visit for the DBM to validate the processes used for calculating the penetration rate measures. The virtual site review included:

- An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- Evaluation of system compliance, including a review of the IS assessment, focusing on the processing of claims, encounters, and member and provider data. HSAG performed PSV on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data systems. Additionally, HSAG evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- Review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with key DBM staff members, allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed.
- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for reporting the selected performance measures. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- A closing conference to summarize preliminary findings from the review of the ISCAT and the virtual review, and to revisit the documentation requirements for any post-review activities.

Description of Data Obtained

MCOs

As identified in the HEDIS Compliance Audit methodology, the following key types of data were obtained and reviewed for fiscal year (FY) 2020–2021 as part of PMV:

1. **FARs:** The FARs, produced by the MCEs' LOs, provided information on the MCEs' compliance to IS standards and audit findings for each measure required to be reported.

2. **Measure Certification Report:** The vendor's measure certification report was reviewed to confirm that all the required measures for reporting had a "pass" status.
3. **Rate Files for the Current Year:** Final rates provided by MCEs in IDSS format were reviewed to determine trending patterns and rate reasonability.

The DBM

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for FY 2020–2021 as part of PMV:

1. **ISCAT:** This was received from the DBM. The completed ISCAT provided HSAG with background information on the DHHS's IS, policies, processes, and data in preparation for the virtual validation activities.
2. **Source Code (Programming Language) for Performance Measures:** This was obtained from the DBM and was used to determine compliance with the performance measure definitions.
3. **Supporting Documentation:** This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
4. **Current Performance Measure Results:** HSAG obtained the results from the measures the DBM calculated.
5. **Virtual Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key DBM staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG collected IDSS files and FARs for MY 2020 from all three MCOs that had been previously audited by a third party LO. HSAG reviewed the documentation to evaluate the accuracy of the data and to identify any issues of noncompliance or problematic performance measures. HSAG then provided recommendations and conclusions to DHHS based on measure rates falling above or below the 25th to 49th performance measure percentile based on NCQA's HMO Quality Compass HEDIS MY 2020 percentile benchmarks.

HSAG also performed a performance validation audit of the DBM for DHHS' selected measures. HSAG evaluated **MCNA**'s eligibility and enrollment data systems, medical services data systems, and data integration process through an ISCAT, source code review, virtual review of the DBM, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by each MCE. HSAG then identified common themes and the salient patterns that emerged across MCEs related to the PMV activity conducted.

How Conclusions Were Drawn

Information Systems Standards Review

MCEs must be able to demonstrate compliance with IS standards. MCEs' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCE compliance with *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.[3-4] The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in Section 2 and the appendices, HEDIS MY 2020 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA-LO according to NCQA standards. With regard to the final measure rates for HEDIS MY 2020, a measure result of *Small Denominator* (*NA*) indicates that the MCE followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the MCE chose not to report the measure.

Performance Measure Results

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

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

[3-4] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

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

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

Measure results for HEDIS MY 2020 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020.

To draw conclusions about the quality and timeliness of, and access to care and services provided by the Medicaid MCEs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-2. The measures marked N/A indicate measure is related to utilization of services.

Table 3-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measures	Quality	Timeliness	Access
Effectiveness of Care: Prevention and Screening			
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
CIS: Childhood Immunization Status	✓	✓	✓
IMA: Immunizations for Adolescents	✓		
LSC: Lead Screening in Children	✓		
BCS: Breast Cancer Screening	✓	✓	✓
CCS: Cervical Cancer Screening	✓		
CHL: Chlamydia Screening in Women	✓		
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis	✓		
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	✓		
PCE: Pharmacotherapy Management of COPD Exacerbation	✓	✓	
AMR: Asthma Medication Ratio	✓		
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure	✓		
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	✓		
Effectiveness of Care: Diabetes Respiratory Conditions			
CDC: Comprehensive Diabetes Care	✓		

Performance Measures	Quality	Timeliness	Access
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management	✓		
ADD: Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
FUH: Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
FUM: Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder	✓	✓	✓
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	✓	✓	✓
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	✓	✓	✓
SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓	✓	✓
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		
Effectiveness of Care: Overuse/Appropriateness			
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
URI: Appropriate Treatment for Upper Respiratory Infection	✓		
LBP: Use of Imaging Studies for Low Back Pain	✓		
HDO: Use of Opioids at High Dosage	✓		
Access/Availability of Care			
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	✓	✓	✓
PPC: Prenatal and Postpartum Care	✓	✓	✓
Utilization			
W30: Well-Child Visits in the First 30 Months of Life	✓		✓
FSP: Frequency of Selected Procedures	NA	NA	NA
AMB: Ambulatory Care (Per 1,000 Member Months)	NA	NA	NA
IPU: Inpatient Utilization—General Hospital/Acute Care—Total	NA	NA	NA
Risk Adjusted Utilization			
PCR: Plan All-Cause Readmissions	✓		
Measures Collected Using Electronic Clinical Data Systems			
BCS-E: Breast Cancer Screening	✓	✓	✓

Assessment of Compliance With Medicaid Managed Care Regulations

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

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

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

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. During CY 2021–2022 HSAG conducted a full review of the Part 438 Subpart D and QAPI standards for all MCEs to ensure compliance with federal

requirements. The objective of each virtual site review was to provide meaningful information to DHHS and the MCEs regarding:

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

Technical Methods of Data Collection

To assess for MCEs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[3-5] Table 3-4 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 3-4—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DHHS contract requirements: • HSAG and DHHS participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with DHHS to develop monitoring tools, record review tools, report templates, agendas, and set review dates. • HSAG submitted all materials to DHHS for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across the MCEs.

[3-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 10, 2021.

For this protocol activity,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCE training webinar to describe HSAG's processes and allow the MCEs the opportunity to ask questions about the review process and MCE expectations. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate. • No less than 60 days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. Forty-five days prior to the review, the MCE provided data files from which HSAG chose sample grievance, appeal, and denial cases to be reviewed. HSAG provided the final samples to the MCEs via HSAG's secure access file exchange (SAFE) site. No less than 30 days prior to the scheduled review, the MCE provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCE Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • At the close of the webinar review, HSAG provided MCE staff members and DHHS personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2021–2022 DHHS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • HSAG analyzed the findings and calculated final scores based on DHHS-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

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

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with key MCE staff members conducted virtually

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from desk review; the review of grievance, appeal, and denial records provided by each MCE; virtual interviews conducted with key MCE personnel; and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCE's performance in complying with each standard requirement.
- Scores assigned to the MCE's performance for each requirement.

- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of Not Met.
- Recommendations for program enhancements.

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

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by each MCE. HSAG then identified common themes and the salient patterns that emerged across MCEs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services provided by the MCEs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the MCEs. Table 3-5 depicts assignment of the standards to the domains of care.

Table 3-5—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection and Program Integrity	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal System	✓	✓	✓

Validation of Network Adequacy

Objectives

HSAG developed the optional NAV activities for Heritage Health MCEs in anticipation and release of the CMS protocol. CY 2021–2022 NAV activities were designed to help DHHS meet the NAV requirements once the EQR protocol is released. In CY 2021–2022, the NAV scope of work was devised to construct a framework from which DHHS can build annual NAV activities that evaluate the accuracy of the MCEs' self-reported compliance with Heritage Health contract standards for access to care. The CY 2021–2022 NAV tasks activities aligned with three general project phases described in Figure 3-1.

Figure 3-1—Summary of CY 2021–2022 NAV Project Phases and Tasks

 Phase 1: Data Collection	 Phase 2: Synthesis & Analysis	 Phase 3: Reporting
Request Data from DHHS • MCEs' Network Adequacy Reports • MCEs' Provider Data ***Develop Provider Data Structure Questionnaire*** • Draft Questionnaire with DHHS Feedback and Approval • Distribute Questionnaire to MCEs • Host Webinar with DHHS and MCEs to Introduce Questionnaire	***Conduct Desk Review of DHHS Documentation*** ***Administer Provider Data Structure Questionnaire*** • Assess MCEs' Questionnaire Responses • Seek Clarifications on MCEs' Responses, if Needed ***Evaluate MCEs' Provider Data*** • Data Field Completeness • Data Field Validity	***Report on NAV Results*** • Submit Draft Report to DHHS • Incorporate DHHS' Feedback • Submit Final, 508-Compliant Report to DHHS

Technical Methods of Data Collection

During CY 2021–2022, HSAG:

- Conducted a desk review of DHHS' existing network adequacy documentation.
- Developed and administered a questionnaire to collect network data structure information from each MCE.
- Assessed the completeness and validity of selected fields critical to network adequacy evaluation from the MCEs' provider data.

Description of Data Obtained

Data obtained included:

- Access to Care Standards associated with the current Heritage Health MCE contracts.
- Information on how each MCE identifies Medicaid providers in its data systems.
- Quarterly network adequacy reporting templates for MCEs.
- The MCEs' network adequacy reports and provider data submission materials.
- DHHS' provider definitions and provider data submission guidelines supplied for the MCEs' use when submitting provider files to DHHS.
- Member-level data from DHHS.
- The managed care network provider data layout(s) and information on the frequency with which the MCEs submit provider data and primary care provider (PCP) attribution lists to DHHS.
- Provider-level network data from each Medicaid MCE, including data values with provider attributes for type (e.g., nurse practitioner), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code.
- Guidelines for the Heritage Health enrollment data maintained by DHHS and the associated data layout (e.g., data dictionary and/or user guide).
- Documentation on the process by which MCEs may request exemptions to the Access to Care Standards and examples of such requests, if available.

How Data Were Aggregated and Analyzed

HSAG's desk review was a qualitative analysis and synthesis of information from a variety of sources to provide an understanding of the current environment for beginning network adequacy validation (NAV). HSAG analyzed the quantitative results obtained from the above NAV activities to identify any barriers to conducting a complete NAV examination beginning in the coming year. Although data will be analyzed in future years to understand MCEs' strengths and weaknesses in the domains of quality, timeliness, and access to services, that was not part of this year's preliminary study of network adequacy.

How Conclusions Were Drawn

HSAG applied a series of quality control examinations to assess the completeness of provider data submitted by the MCEs including the following:

- Examination of missingness
  - *For each data element, how many records contain a non-null data value?*
  - *If missing values are expected under certain scenarios, are data values missing as expected?*

- Verification of valid formats and valid values within an expected range
  - *Do populated data values align with the allowable data values identified in DHHS' data documentation? For example:*
    - *Are national provider identifiers (NPIs) populated with data values found in the National Plan and Provider Enumeration System (NPPES)?*
    - *If a data element is intended to be populated with "Y," "N," or "U," are these the only values present in the data?*
- Generation of record counts among records with valid values
  - *What is the count and percentage of provider records that include an additional language spoken?*
- Selected cross-element evaluations of data validity
  - *How many records include inconsistent data values across selected elements? For example:*
    - *Are the provider type and/or specialty inconsistent with the PCP indicator (e.g., a specialty of "pharmacy" with an indicator for a PCP)?*
    - *Are there unique providers associated with an unlikely number of multiple service locations (e.g., an individual associated with more than 10 unique service locations)?*

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and access to care furnished by each MCE, as well as the program overall. To produce Nebraska's CY 2021–2022 Technical Report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and access to care and services provided by the MCEs:

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

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

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

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

Validation of Performance Improvement Projects

Results

HBN submitted the *Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)* PIP for the CY 2021–2022 validation cycle. The PIP received an overall *Met* validation status for the initial submission, and the MCO chose not to resubmit the PIP. Table A-1 illustrates the validation scores.

Table A-1—2021–2022 PIP Validation Results for HBN

PIP Title	Type of Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)	Initial Submission	89%	100%	*Met*

Table A-2 displays performance indicator results for **HBN**'s *Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)* PIP.

Table A-2—Performance Indicator Results for HBN

PIP Performance Indicator	Baseline (1/1/2019 to 12/31/2019)		Remeasurement 1 (1/1/2020 to 12/31/2020)		Sustained Improvement
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	N: 487 D: 632	77.06%	N: 542 D: 743	72.95%	*Not Assessed*

N–Numerator; D–Denominator

For the baseline measurement period, **HBN** reported that 77.06 percent of targeted members who were dispensed an antipsychotic medication received a diabetes screening test during the measurement year. For the first remeasurement period, **HBN** reported that 72.95 percent of targeted members who were dispensed an antipsychotic medication received a diabetes screening test during the measurement year. The results from the first remeasurement represented a decline of 4.11 percentage points from baseline indicator performance.

Interventions

For the *Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)* PIP, **HBN** used pharmacy, medical claims, and survey data to identify barriers to improving performance indicator outcomes. To address the identified barriers, **HBN** carried out the following interventions:

- Targeted provider education outreach for those providers who are low performing on the SSD measure (i.e., 50 percent or fewer eligible members have received a diabetes screening test).
- Distribution of care gap reports to PCP offices, highlighting members who are due or overdue for a diabetes screening test in compliance with the SSD measure.
- Care management services offered to all members who were dispensed a new antipsychotic medication.
- Telephonic education outreach to members within two months of the initial antipsychotic medication dispensing date.

Strengths

The PIP validation findings suggest a thorough application of the PIP Design stage (steps 1 through 6). A methodologically sound design created the foundation for **HBN** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

In the Implementation stage (steps 7 and 8), **HBN** progressed to reporting performance indicator results from the first remeasurement (interim) period and initiated interventions linked to identified barriers to improvement. The MCO accurately reported performance indicator data for each measurement period. **HBN** also conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement in the Implementation and Outcomes stages of the PIP. In the Implementation stage, **HBN** did not report statistical testing results comparing performance between the baseline and first remeasurement period. **[Quality]**

In the Outcomes stage, the first remeasurement results for the PIP performance indicator demonstrated a decline from baseline performance. **[Quality, Timeliness, and Access]**

To address identified opportunities for improvement, HSAG recommended the following for **HBN**:

- Conduct statistical testing as part of the analyses of performance indicator remeasurement results. The results of each annual remeasurement should be compared to the baseline results to determine if

statistically significant improvement was demonstrated. The MCO should request technical assistance with statistical testing from HSAG, as needed, to ensure that appropriate statistical testing is completed and accurately reported. **[Quality]**

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

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

HBN reported to HSAG that the following EQR recommendations were identified during CY 2020–2021 by the previous EQRO:

- Ensure that, going forward, if all CMS Adult Core Set and Child Core Set measures continue to be required, they appear in the workbooks and reports submitted to MLTC.

HBN reported engaging in the following quality improvement initiatives to address the prior year's recommendations:

- Both Title XIX (Medicaid) and Title XXI (CHIP) populations were surveyed and their results stratified.
- The required performance measures were listed in the 2020 Quality Management Work Plan, 2020 Quality Management Program Evaluation, and State-required workbook.
- CAHPS responses were stratified.

HSAG determined that by conducting the above activities, **HBN** adequately addressed the CY 2020–2021 recommendations. It should be noted that PIP scores assigned by the previous EQRO in CY 2020–2021 are not comparable to PIP scores assigned by HSAG in CY 2021–2022. HSAG used its own PIP scoring methodology for PIP validation in CY 2021–2022. In CY 2021–2022, HSAG's scope of work included validation of only the *Diabetes Screening for Members Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)* PIP. HSAG provided technical assistance on the PCR PIP design to **HBN** in CY 2021–2022 and the MCO will submit the PCR PIP for the CY 2022–2023 validation cycle. HSAG will report validation findings and recommendations for the PCR PIP in the CY 2022–2023 technical report.

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated **HBN**'s IS capabilities for accurate HEDIS reporting. HSAG reviewed **HBN**'s FARs for its LO's assessment of IS capabilities assessments, specifically focused on those system aspects of **HBN**'s system that could have impacted the HEDIS Medicaid reporting set.

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

In accordance with NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that **HBN**'s IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. **HBN** may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

The section that follows provides a summary of **HBN**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in Appendix E of this report.

Table A-3—Summary of Compliance With IS Standards for HBN

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored.	The LO determined that **HBN** was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that **HBN** only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCEs continually assess data completeness and take steps to improve performance. • The MCEs effectively monitor the quality and accuracy of electronic submissions. • The MCEs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**HBN** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **HBN** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**HBN** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **HBN** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **HBN** reviewed all provider data received from delegated entities.
IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate.	**HBN** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
• Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for electronic clinical data system (ECDS) reporting met reporting requirements. • NCQA-certified eCQM (electronic clinical quality measure) data met reporting requirements.	**HBN** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in non-standard form that required PSV.
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**HBN** was compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by **HBN**'s staff members. Data were verified for accuracy at each data merge point.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**HBN** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA HEDIS Certified Measures vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **HBN**. According to the DHHS's required data collection methodology, the rates displayed in Table A-4 reflect all final reported rates in **HBN**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **HBN** may have received an "*NA*" designation for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table A-4—HEDIS Audit Results for HBN

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

Table A-5—HBN's HEDIS Measure Rates and Audit Results

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
Effectiveness of Care: Prevention and Screening		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	67.40% ★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	68.61% ★★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	64.48% ★★★	***R***
CIS: Childhood Immunization Status—Combination 2	72.75% ★★★★	***R***
CIS: Childhood Immunization Status—Combination 3	70.80% ★★★★	***R***
CIS: Childhood Immunization Status—Combination 10	47.69% ★★★★★	***R***
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	75.18% ★★★	***R***
LSC: Lead Screening in Children	72.26% ★★★★	***R***
BCS: Breast Cancer Screening	40.62% ★	***R***
CCS: Cervical Cancer Screening	63.99% ★★★★★	***R***
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	29.24% ★	***R***
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	40.39% ★	***R***
CHL: Chlamydia Screening in Women—Total	32.97% ★	***R***
Effectiveness of Care: Respiratory Conditions		
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17 Years	73.83% ★★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64 Years	63.57% ★★★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 65 and older	NA	***NA***
CWP: Appropriate Testing for Pharyngitis—Total	72.20% ★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.30% ★★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	34.02% ★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	43.44% ★	***R***
AMR: Asthma Medication Ratio—Ages 5 to 11	72.64% ★★	***R***
AMR: Asthma Medication Ratio—Ages 12 to 18	58.84% ★	***R***
AMR: Asthma Medication Ratio—Ages 19 to 50	55.49% ★★★	***R***
AMR: Asthma Medication Ratio—Ages 51 to 64	59.46% ★★★★	***R***
AMR: Asthma Medication Ratio—Total	63.42% ★★★	***R***
Effectiveness of Care: Cardiovascular Conditions		
CBP: Controlling High Blood Pressure	52.80% ★★★	***R***
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	***NA***
Effectiveness of Care: Diabetes		
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	84.91% ★★★★	***R***
*CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	45.74% ★★★	***R***
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	45.01% ★★★	***R***
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.07% ★★★★	***R***
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.02% ★★★★	***R***
Effectiveness of Care: Behavioral Health		
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.99% ★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	40.25% ★★★	***R***
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	44.11% ★★★	***R***
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	56.72% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	55.00% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	75.00% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	34.57% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	54.26% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	42.19% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.17% ★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	41.79% ★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	61.59% ★★★★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder Illness—7-Day Follow-Up—Total	27.43% ★★★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	42.29% ★★★	***R***
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	11.04% ★★★	***R***
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	14.05% ★★★	***R***
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	73.25% ★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	53.19% ★	***R***
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	***NA***
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.61% ★★★	***R***
Effectiveness of Care: Overuse/Appropriateness		
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females[*]	0.31% ★★★★	***R***
URI: Appropriate Treatment for URI—Ages 3 Months to 17 Years	88.71% ★★	***R***
URI: Appropriate Treatment for URI—Ages 18 to 64 Years	77.84% ★★★	***R***
URI: Appropriate Treatment for URI—Ages 65 Years and Older	94.32% ★★★★★	***R***
URI: Appropriate Treatment for URI—Total	87.51% ★★★	***R***
LBP: Use of Imaging Studies for Low Back Pain	76.84% ★★★★	***R***
HDO: Use of Opioids at High Dosage[*]	4.75% ★★★★	***R***
Access/Availability of Care		
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment— Total— Ages 13 to 17	59.51% ★★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment— Total— Ages 13 to 17	25.37% ★★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment— Total— Ages 18 and Older	54.16% ★★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total— Ages 18 and Older	16.43% ★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total— Total	54.88% ★★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total— Total	17.62% ★★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.32% ★★★	***R***
PPC: Prenatal and Postpartum Care—Postpartum Care	77.13% ★★★★	***R***
Utilization		
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.95% ★★★★★	***R***
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	72.67% ★★★★	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^	0.09 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^	0.20 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^	0.60 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^	0.26 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^	0.10 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^	0.14 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—15–44 Years—Female^	0.17 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^	0.17 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^	0.00 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^	0.01 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^	0.03 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^	0.34 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^	0.76 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^	0.51 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^	0.46 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^	0.80 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^	0.20 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^	1.06 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^	0.05 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^	0.31 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^	0.11 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^	0.40 NC	***R***
AMB: Ambulatory Care—Emergency Department Visits^,*	36.29 ★★★★	***R***
AMB: Ambulatory Care—Outpatient Visits^	293.10 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care –Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^	7.82 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Total Inpatient—Total All Ages	4.60 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Maternity—Total All Ages^*	5.52 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Maternity—Total All Ages	2.41 NC	***R***
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Surgery—Total All Ages^*	1.28 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Surgery—Total All Ages	9.00 NC	***R***
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Medicine—Total All Ages^*	3.66 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Medicine—Total All Ages	4.77 NC	***R***
Risk Adjusted Utilization		
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	10.51% ★★★	***R***
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.27% NC	***R***
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	0.93 NC	***R***
Measures Collected Using Electronic Clinical Data Systems		
BCS-E: Breast Cancer Screening	—	***NR***

^ Rate is reported per 1,000 member months rather than a percentage.
NC indicates that a comparison to the HEDIS MY 2020 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MCOs followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.
** For this indicator, a lower rate indicates better performance.*
HEDIS MY 2020 Performance Levels represent the following percentile comparisons:
★★★★★ *= 75th percentile and above*
★★★★ *= 50th to 74th percentile*
★★★ *= 25th to 49th percentile*
★★ *= 10th to 24th percentile*
★ *= Below 10th percentile*

Table A-6—HBN's CMS Core Set Measure Rates

CMS Core Set Measures*	MY 2020 Rate
Adult Core Set Measures	
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder	NR
PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate	NR
Child Core Set Measures	
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages <1^	58.28
AMB-CH: Ambulatory Care: Emergency Department (ED) Ages 1 to 9^	23.93
AMB-CH: Ambulatory Care: Emergency Department (ED) Ages 10 to 19^	20.95
AUD-CH: Audiological Diagnosis No Later than 3 Months of Age	NR
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17	NR

* The MCO's self-reported CMS Adult Core Set and Child Core Set measures were not audited and rates are presented for information only.

^ Rate is reported per 1,000 member months rather than a percentage.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* and *Cervical Cancer Screening* measure indicators were a strength for **HBN**. **HBN** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* rates demonstrate that children 2 years of age are receiving immunizations for disease prevention to help protect them against the potential of a life threatening illness and the spread of preventable diseases at a time in their lives when they are vulnerable.[A-1, A-2] In addition, the *Cervical Cancer Screening* rate demonstrates women ages 21 to 64 were receiving screening for one of the most common causes of cancer death in the United States. The effective screening and early detection of cervical cancer have helped reduce the death rate in this country.[A-3] **[Quality, Timeliness, and Access]**

[A-1] Mayo Clinic. 2014. "Infant and Toddler Health Childhood Vaccines: Tough questions, straight answers. Do vaccines cause autism? Is it OK to skip certain vaccines? Get the facts on these and other common questions." Available at: http://www.mayoclinic.com/health/vaccines/CC00014. Accessed on: Oct 28, 2021.

[A-2] Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief.

[A-3] American Cancer Society. 2020. "Key Statistics for Cervical Cancer." Last modified January 12, 2021. Available at: https://www.cancer.org/cancer/cervicalcancer/about/key-statistics.html. Accessed on: Oct 28, 2021.

In addition, the *Lead Screening in Children* measure was also a strength for **HBN**. **HBN** for the measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The rate demonstrated by *Lead Screening in Children* shows children under 2 years of age are adequately receiving a lead blood test to ensure they are maintaining limited exposure to lead. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 51 to 64* measure indicator was a strength for **HBN**. **HBN** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This rate indicates that **HBN** providers are handling asthma appropriately for this age group as a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs to all stakeholders involved.[A-4] **[Quality]**

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for **HBN**. **HBN** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. According to NCQA (as cited by the CDC), proper management is needed to control blood glucose levels, reduce risk of complications, and extend members' lives. Care providers can help members by prescribing and instructing proper medication practices, dietary regimens, and proper lifestyle choices such as exercise and quitting smoking.[A-5] **[Quality]**

Effectiveness of Care: Behavioral Health Domain

HBN for the following measures indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark:

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17*, *30-Day Follow-Up—Ages 6 to 17*, *7-Day Follow-Up—Ages 18 to 64*, *30-Day Follow-Up—Ages 18 to 64*, *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

Based on these rates, **HBN** providers were able to follow up with children after being diagnosed with ADHD through the continuation of their treatment to ensure their medication levels were managed appropriately to help manage attention and impulsive disorders. Also, **HBN** providers were

[A-4] Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Oct 28, 2021.

[A-5] Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services.

appropriately managing care for patients hospitalized or discharged after an ED visit for mental health issues, as they are vulnerable after release. Follow-up care by trained mental health clinicians is critical for successfully transitioning out of an inpatient setting as well as preventing readmissions. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Imaging Studies for Low Back Pain* and *Non-Recommended Cervical Cancer Screening in Adolescent Females* measures were a strength for **HBN**. **HBN** for these measures ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The rate for *Use of Imaging Studies for Low Back Pain* indicates **HBN** members did not have an imaging study within 28 days of the diagnosis. Evidence has shown that unnecessary imaging for low back pain does not improve outcomes and exposes members to harmful radiation and unnecessary treatment.[A-6] As shown by the *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate, **HBN** providers were effectively not providing unnecessary cancer screening which can be potentially harmful to the patient and unwarranted. **[Quality]**

The *Use of Opioids at High Dosage* measure was also a strength for **HBN**. **HBN** for this measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This rate demonstrates that **HBN** providers limited the use of prescription opioids for members 18 years and older. In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States.[A-7] Of those, 40 percent involved prescription opioids.[A-18] Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose.[A-8, A-9, A-10] **[Quality]**

The *Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older* measure indicator was also a strength for **HBN**. **HBN** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. This indicates that members with a diagnosis of URI did not result in an antibiotic dispensing event. **[Quality]**

Access/Availability of Care Domain

All *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* measure indicators were also a strength for **HBN**. **HBN** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates that adolescents 13 years of age and older initiated treatment within 14 days of diagnosis, engaged in treatment, and had two

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A-6 National Committee for Quality Assurance. *Use of Imaging Studies for Low Back Pain*. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 15, 2021.

A-7 U.S. Department of Health and Human Services (HHS). 2019. "What is the U.S. Opioid Epidemic?" Updated September 4, 2019. Available at: https://www.hhs.gov/opioids/about-the-epidemic/index.html. Accessed on: Oct 28, 2021.

A-8 Dunn, KM, Saunders KW, Rutter CM, et al. 2010. "Overdose and Prescribed Opioids: Associations Among Chronic Non-Cancer Pain Patients." *Annals of Internal Medicine* 152(2), 85–92

A-9 Gomes T, Mamdani MM, Dhalla IA, et al. 2011. Opioid Dose and Drug-Related Mortality in Patients With Nonmalignant Pain. *Arch Intern Med* 171:686–91.

A-10 Paulozzi LJ, Jones C, Mack K. et al. 2011. "Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008." *MMWR* 60(43):1487–92.

or more additional AOD services or MAT within 34 days of the initiation visit. **[Quality, Timeliness, and Access]**

The *Prenatal and Postpartum Care—Postpartum Care* measure indicator was also a strength for **HBN**. **HBN** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. Studies indicate that as many as 60 percent of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care, and made changes in their health and lifestyle habits.[A-11] Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[A-12] **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits Age 15 Months to 30 months—Two or More Well-Child Visits* measure indicators were also a strength for **HBN**. **HBN** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates children within the first 15 to 30 months of life were seen by a PCP in order to help influence and assess the early development stages of the child. **[Quality and Access]**

In addition, the *Ambulatory Care—Emergency Department Visits—Total* measure indicator was a strength for **HBN**. **HBN** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark, suggesting appropriate utilization of services.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total* measure indicator was a weakness for **HBN**. **HBN** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Child obesity has more than doubled over the last three decades and tripled in adolescents.[A-13] HSAG recommended that **HBN** and its providers strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. If the rate in children and adolescents receiving these services is identified to be related to

[A-11] Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Available at: https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf. Accessed on: Oct 28, 2021.

[A-12] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

[A-13] Centers for Disease Control and Prevention (CDC). 2013 "Adolescents and School Health: Childhood Obesity Facts." Available at: http://www.cdc.gov/healthyyouth/obesity/facts.htm. Accessed on: Oct 28, 2021; and American Heart Association. 2013. "Overweight in Children."

the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for improved access to these services. **[Quality]**

The *Breast Cancer Screening* measure was also a weakness for **HBN**. **HBN** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. This rate indicates women were not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment and higher health care costs. HSAG recommended that **HBN** conduct a root cause analysis or focus study to determine why its female members are not receiving preventive screenings for breast cancer. DHHS and **HBN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **HBN** should implement appropriate interventions to improve performance. If the rate in women receiving these services is identified to be related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for improved access to these services. **[Quality, Timeliness, and Access]**

The *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years,* and *Total* measure indicators were a weakness for **HBN**. **HBN** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications. This includes PID, infertility, and increased risk of becoming infected with HIV-1. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[A-14] HSAG recommended that **HBN** providers follow up annually with sexually active members through any type of communication to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for **HBN**. **HBN** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. HSAG recommended that **HBN** conduct a root cause analysis for the *Appropriate Testing for Pharyngitis* measure to determine why members are not being tested. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics.[A-15] If the low rate in members accessing these services is identified as related to the COVID-19 public health

[A-14] Meyers DS, Halvorson H, Luckhaupt S. 2007. "Screening for Chlamydial Infection: An Evidence Update for the U.S. Preventive Services Task Force." *Ann Intern Med* 147(2):135–42.

[A-15] Centers for Disease Control and Prevention. 2013. "Strep Throat: All You Need to Know." Available at: http://www.cdc.gov/Features/strepthroat/. Accessed on: Oct 28, 2021.

emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure was a weakness for **HBN**. **HBN** for this measure ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.[A-16] HSAG recommended that DHHS ensure **HBN** and its providers are aware of spirometry testing to help create a treatment plan for members with COPD. **[Quality]**

The *Asthma Medication Ratio—Ages 5 to 11* and *Ages 12 to 18,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators were a weakness for **HBN**. **HBN** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. These rates indicate that **HBN** providers are not handling asthma appropriately as a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs for all stakeholders involved.[A-17] HSAG recommended that **HBN** conduct a root cause analysis to determine if the rate of the *Asthma Medication Ratio* measure is being affected due to an access to care or management of member medication issue. In addition, based on the rate, **HBN** providers are not appropriately prescribed medication to prevent and help members control their COPD related to the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease.[A-18] However, symptoms can be controlled with appropriate medication.[A-19, A-20] Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. HSAG recommended that **HBN** work with its pharmacy data to identify opportunities to refill prescriptions in a timelier manner and to assist members with barriers to refilling prescriptions (e.g., members needing transportation to the pharmacy or possible billing challenges at the point of sale). **[Quality and Timeliness]**

[A-16] National Committee for Quality Assurance. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*. Available at: https://www.ncqa.org/hedis/measures/use-of-spirometry-testing-in-the-assessment-and-diagnosis-of-copd/. Accessed on: Oct 15, 2021.

[A-17] Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Oct 28, 2021.

[A-18] Pasquale MK, Sun SX, Song F, et al. "Impact of exacerbations on health care cost and resource utilization in chronic obstructive pulmonary disease patients with chronic bronchitis from a predominantly Medicare population." *International Journal of COPD* 7:757-64. doi: 10.2147/COPD.S36997.

[A-19] National Heart, Lung, and Blood Institute. 2012. "Morbidity and Mortality: 2012 Chart Book on Cardiovascular, Lung, and Blood Diseases."

[A-20] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, and Prevention of Chronic Obstructive Pulmonary Disease."

Effectiveness of Care: Behavioral Health Domain

The *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People with Diabetes and Schizophrenia* measures were a weakness for **HBN**. **HBN** for these measures ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Because members with serious mental illness (SMI) who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death.[A-21] HSAG recommended that **HBN** review its data production process for this measure to ensure no claims are missing and all available data are being collected for the measure. **HBN** might also consider performance-based incentives for its behavioral health provider network to ensure that all providers are prioritizing physical health screenings for high-risk members. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **HBN**. **HBN** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommended that **HBN** conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[A-22] In addition, HSAG recommended that providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

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

During CY 2020–2021 the following EQR recommendations were identified:

- Ensure that, going forward, if all CMS Adult Core Set and Child Core Set measures continue to be required, they appear in the workbooks and reports submitted to MLTC.
- Develop interventions to specifically target performance for those HEDIS MY 2019 measures that are at or below the national Medicaid HMO average.

[A-21] National Committee for Quality Assurance. *Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder*. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Oct 15, 2021.

[A-22] National Committee for Quality Assurance. *Appropriate Treatment for Children with Upper Respiratory Infection*. Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-children-with-upper-respiratory-infection/. Accessed on: Oct 15, 2021.

HBN reported engaging in the following quality improvement initiatives:

- Annual report documents were submitted to MLTC. The results of performance measures chosen by MLTC were to improve quality of care and members' health outcomes. The required performance measures were listed in the 2020 Quality Management Work Plan, 2020 Quality Management Program Evaluation, and State required workbook.
- The following interventions were developed to specifically target performance for the HEDIS MY 2019 measures that were at or below the national Medicaid HMO average:
  - *Cervical Cancer Screening*—Implemented member incentives which helped drive members' interest in their preventive health.
  - *Chlamydia Screening (CHL)*—Implemented member incentives and member outreach to help members make their appointments.
  - *Well-Child/Adolescence Primary Care Provider Visits*—Patient Care Advocates (PCA) conducted direct member outreach to assist members in making appointments to close care gaps. The upward trend suggests the effectiveness of the previously implemented interventions despite the COVID-19 implications.
  - *Age-Appropriate Immunizations* - The Plan initiated a texting campaign on Baby First Program and a call campaign to pregnant members to educate on the importance of Tdap during pregnancy.
  - *Blood Lead Screening/Testing*—The collaboration efforts with the Children's Hospital and were able to educate our members on lead testing, and other health literacy topics. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mailings support LCS measures by providing this information in direct mailing. Texting campaign and member/provider newsletter.
  - *Postpartum Care & Timeliness of Prenatal*—In 2021, the Plan will implement New Baby, New Life CM Program to continue outreach and coordination of care to pregnant members. Use of telehealth during the COVID-19 pandemic has aided its efforts in closing gaps concerning access and health equity. In 2020, member education via newsletter about importance of postpartum care; educated members about baby first and CM/DM program and available resources via e-newsletter; community impact WIC Moms and Babies; launched a radio script about Baby First Program; and disseminated baby First Program info sheet.
  - *Medication Management for People With Asthma*—In 2020, the plan launched a letter campaign and outreach to 88 Nebraska prescribers regarding members (89) who were identified as continuously (>90 days) receiving two or more antipsychotic medications. **HBN** continued identifying and outreaching physicians regarding appropriateness of gabapentinoid therapeutic duplication for members receiving Medication Therapy Management Services.
  - *Asthma Medication Ratio*—The Asthma Disease Management program assists with education, asthma action plans, and self-management for members with Asthma.
  - *FUH: 7-Day Follow-Up After Hospitalization for Mental Illness (FUH) measure indicator*—Members discharged from the ED with a mental health diagnosis were reported to the plan biweekly through a State Health Information Exchange system starting in 2019. These members were telephonically outreached and offered education on the importance of a follow-up

appointment within a week of discharge. This intervention impacted the 7-day follow-up rate for children in the age group 6–17.

- *Follow-Up After Emergency Department Visit for Mental Illness*—Two weeks after the ED discharge with a mental health diagnosis, members were telephonically outreached and screened for Care Management and social determinants of health. Members prescribed an antipsychotic medication were outreached and offered education on the importance of monitoring, recommended health screenings, and identifying additional needs such as CM or resources to overcome their health barriers.
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*—Education and coordination for these members continues to be important especially given the relationship between these members physical and mental health.
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)—SSD Performance Improvement Project*—New member phone campaign was initiated to attempt outreach to all members with a new prescription of an antipsychotic medication for education and identification of member resource needs. Additionally, an internal behavioral health (BH) workgroup was created to drive further discussions and interventions surrounding BH. It is too early to determine if the member phone campaign implemented was effective.
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*—In 2021-Annual HEDIS brochure to providers that includes SAA Measure.

- Combining the diabetes DM program and member and provider incentive programs have contributed to a decline in diabetic short-term complications admission rates.
- Telephonic outreach to members after two weeks after the ED discharge with a mental health diagnosis and screened for Care Management and social determinants of health.
- Members prescribed an antipsychotic medication were outreached and offered education on the importance of monitoring, recommended health screenings, and identifying additional needs such as CM or resources to overcome their health barriers.
- Included a detailed meeting schedule in the Member Advisory Committee (MAC) Charter so that members can plan accordingly.
- Both Title XIX (Medicaid) and Title XXI (CHIP) populations are surveyed and their results stratified.
- **HBN**'s Complex Case Management program focuses on the timely, proactive, collaborative, and member-centric coordination of services for individuals identified with complex medical conditions. Members are identified through our proprietary predictive modeling that may include medical diagnosis or condition, high utilization of services, financial or utilization-based triggers, health risk assessments, or electronic health records.
- **HBN**'s Population Health Program utilize predictive modeling, findings from early identification screenings, gaps in care (GIC) data and comprehensive clinical assessments to assist the member with care plan development, which is intended to meet needs proactively, optimize care, and reduce the need for emergency and hospital healthcare services.

- The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. The EPSDT program provides for assessment of the child's health needs through initial and periodic examinations and evaluations, and also assures that health problems are diagnosed and treated early, before they become more complex and treatment costlier.
- Clinical Pharmacy Care Programs conducted by specially trained clinical pharmacists and certified/licensed pharmacy technicians who provide the initial outreach for medication adherence.
- Opioid Programs and Controlled Substance Utilization Monitoring (CSUM): **HBN**'s in-house Pharmacy Benefit Manager (PBM) Opioid Management program helps reduce the misuse of opioids by targeting outlier provider opioid prescribing patterns and helping members gain access to more clinically appropriate treatment.
- Connected members to local resources to help then to meet their needs as it relates to social determinants of health by implementing and communicating via member flyer and website about the Aunt Bertha tool.
- Collaborative QM and BH workgroup implemented the following:
  - Implemented a new member outreach campaign to assist members with a hospital discharge secondary to mental illness with scheduling of follow up appointments and screening for needed resources
  - Implemented new staff and training to monitored and resolve Quality of Care/Adverse event cases timely.
  - Conducted oversight of delegated services and activities with 99 percent of audits completed timely.
  - Standardization of File Review Tools and Methodology for use across the department addressing contract, federal, state and NCQA requirements
  - Improved management of the Disease and Care management programs.
  - Developed and implement programs for members with special needs.
  - Launched the Availity Maternity HEDIS Attestation tool requires OB clinics to notify **HBN** if an **HBN** patient is pregnant during the check-in process.

HSAG determined that by conducting the above activities addressed some, but not all recommendations in CY 2020–2021. HSAG continues to recommend that **HBN** provide all required CMS Adult Core Set and Child Core Set measures required by MLTC for reporting purposes. In addition, HSAG recommended that **HBN** develop interventions to all HEDIS MY 2020 measures that are falling between below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark in order to improve quality of care.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table A-7—Summary of Scores for Each Standard for HBN

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
I. Enrollment and Disenrollment	7	7	7	0	0	100%
II. Member Rights and Confidentiality	6	6	5	1	0	83%
III. Member Information	22	22	17	5	0	77%
IV. Emergency and Poststabilization Services	12	12	12	0	0	100%
V. Adequate Capacity and Availability of Services	14	14	12	2	0	86%
VI. Coordination and Continuity of Care	9	9	9	0	0	100%
VII. Coverage and Authorization of Services	19	19	16	3	0	84%
VIII. Provider Selection and Program Integrity	16	16	15	1	0	94%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	100%
X. Practice Guidelines	3	3	3	0	0	100%
XI. Health Information Systems	6	6	6	0	0	100%
XII. Quality Assessment and Performance Improvement	6	6	6	0	0	100%
XIII. Grievance and Appeal System	26	26	20	6	0	77%
Totals*	**150**	**150**	**132**	**18**	**0**	**88%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Table A-8 presents the number of elements for each record type; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for CY 2021–2022.

Table A-8—Summary of HBN Scores for the CY 2021–2022 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Grievances	50	40	37	3	10	93%
Appeals	70	61	61	0	9	100%
Denials	60	50	47	3	10	94%
Totals*	**180**	**151**	**145**	**6**	**29**	**96%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Strengths

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

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

HBN achieved full compliance for the appeals record reviews. **[Quality, Timeliness, and Access]**

HBN achieved full compliance for the Enrollment and Disenrollment standard, demonstrating the MCE had policies and procedures that included all required provisions. Members are accepted into the health plan without restriction. Appropriate processes were in place related to member and MCE requests for disenrollment. **[Quality and Access]**

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

HBN achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for their care management program. **HBN** implemented an extensive list of procedures to coordinate members services between setting of care and with community and social support agencies. **[Quality, Timeliness, and Access]**

HBN achieved full compliance in the Subcontractual Relationships and Delegation standard, demonstrating the MCE had proper oversight and management with contracted vendors. Based on

HSAG's review of Delegation/Vendor Oversight Management Committee meeting minutes, the committee met regularly and reviewed performance indicator reports of delegated functions. **[Quality]**

HBN achieved full compliance in the Practice Guidelines standard, demonstrating the MCE had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. Guidelines were disseminated to all providers, and upon request to members and potential members. **[Quality]**

HBN achieved full compliance in the Health Information Systems standard, demonstrating the MCE had processes in place for how information is captured, processes, and stored in the MCE's data warehouse. **HBN**'s various data management programs afforded **HBN** the capability to capture and report on utilization patterns, claims, complaints, grievances, appeals, and provider and member demographic information. **[Quality and Access]**

HBN achieved full compliance in the Quality Assessment and Performance Improvement standard, demonstrating the MCE had maintained a well-developed, thorough, and continuous QAPI program. **HBN**'s program outlined activities such as performance improvement projects, performance measures, mechanisms to detect both underutilization and overutilization of services, and means of assessing the quality and appropriateness of care for members with special health care needs. **[Quality]**

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

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

HBN received a score of 83 percent in the Member Rights and Confidentiality standard. **HBN** must expand the Advance Directives policy to include a provision to notify members 90 days after the effective date of any changes in State laws regarding advance directives. Although the member handbook included what members should do if a provider had limitations to implementing an advance directive as a matter of conscience, it did not speak to **HBN**'s limitations. **HBN** staff members reported no known limitations; therefore, HSAG recommended clarifying this in member materials. **[Access]**

HBN received a score of 77 percent in the Member Information standard. **HBN** must update the member handbook to include the following tagline requirements: include taglines in a large font size that is conspicuously visible; add the prevalent non-English language tagline; ensure taglines are in a prominent location in all critical member materials. Additionally, **HBN** must update internal procedures to ensure timely mailings and add details within member materials to inform the member of the right to receive materials in paper form within five business days following the request. If the vendor RR Donnelley is used for ad hoc mailing requests, the vendor agreement must also be updated to ensure the five-business-day delivery time frame. In addition, **HBN** must update the policy and procedure to reflect that members will receive notification of a provider termination within 15 calendar days after receipt *or 30 calendar days prior to the effective date, whichever is later*. Also, **HBN** must add details regarding

how the member may obtain a printed copy of the provider directory to the welcome flier or relevant welcome materials. **HBN** must update the member handbook to: clarify that an appeal is only in response to an adverse benefit determination; remove the requirement that a verbal appeal is followed by a written appeal; remove the criteria "the time or service limits of a previously approved service have ended" from the State fair hearing continuation of benefits section. HSAG recommended **HBN** clarify the policy to match its practice, that a machine-readable version is available to members on the **HBN** website. Furthermore, HSAG recommended adding such a statement in the member and provider materials and include details about what the member or provider should do if a provider has any objections (i.e., the member should contact member services to be re-assigned; details about how the provider should inform new members). **[Access]**

HBN received a score of 86 percent in the Adequate Capacity and Availability of Services standard. **HBN** must define its ADA requirements for individual providers and provider facilities and enhance its mechanism for monitoring and ensuring accommodations for members with physical or mental disabilities or limited English proficiency. Additionally, **HBN** must develop a mechanism to review its Nebraska membership to identify unique cultural needs or barriers to care and develop a comprehensive plan to engage Nebraska members, staff members, and providers in corresponding outreach and/or educational opportunities. In addition to the required actions, HSAG recommended that **HBN** define "adequate choice" for the purposes of their measurements and should expanded its policy to include all details and ensure they are included in the monitoring process. **[Timeliness and Access]**

HBN received a score of 84 percent in the Coverage and Authorization of Services standard. **HBN** must ensure that urgent/expedited requests for continued inpatient stay are processed within the required 72-hour time frame. Additionally, **HBN** must revise its policies and procedures and develop a mechanism to ensure that, if **HBN** extends the time frames for making standard or expedited authorization decisions, it provides notice to the member of the reason for the delay and informs the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame. In addition to the required actions, HSAG recommended that when providers are notified of an overturn of the decision as a result of the reconsideration or peer-to-peer review, that members receive a copy of the notification, or an equivalent notification, as well. Since a resolution letter is not required for the informal processes and members do not receive the message of approval after they have received the Notice of Adverse Benefit Determination (NABD), they may be reluctant to schedule the care. **[Timeliness and Access]**

HBN received a score of 94 percent in the Provider Selection and Program Integrity standard. **HBN** must develop administrative and/or management procedures to detect and prevent FWA to address or comply with 42 CFR §438.608(a)(6-8). Additionally, HSAG recommended **HBN** update and align policies, procedures, and provider materials regarding the medical record retention time frame. **[Quality, Timeliness, and Access]**

HBN received a score of 77 percent in the Grievance and Appeal standard. **HBN** must investigate each grievance and act on it, to the extent possible, based on the initial contact from the member, as the member has expressed dissatisfaction. **HBN** may need to consider revising processes so that enough information can be obtained during the initial member contact. Furthermore, **HBN** must ensure that, for all grievances received by the MCO, the member is sent a written notice of resolution in a format and

language that may be easily understood by the member. Additionally, **HBN** must revise policies, procedures, and all applicable documents to clearly inform members, staff members, and providers that a written appeal is not required and that members may file appeals orally with no further follow-up required. In addition to reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution, which HSAG found in the documentation, **HBN** must also follow up within two calendar days with a written notice of the denial of expedition that also informs the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. Moreover, **HBN** must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal. Furthermore, **HBN** must change its applicable policies and related documents to remove the expiration of the authorization as an event that would trigger the end of continued services as well as remove the statement that the authorization having not yet expired is a condition of continuing services during the State fair hearing. Also, **HBN** must ensure that, at the time of entering a contract with the MCO, providers are furnished complete and accurate information about the member grievance and appeal system. While **HBN**'s policies, procedures, and member and provider informational documents included an accurate definition of "adverse benefit determination," the grievance resolution notices offered the member an appeal. A grievance resolution is not an event that is included in the definition of "adverse benefit determination" and therefore is not subject to appeal. During the interview, staff members were unaware of this language in the grievance resolution notices. HSAG recommended that this be removed from the grievance resolution template. Importantly, HSAG recommended that **HBN** review its policies on "similar specialty reviewer" and use of external specialty reviewers when needed, and ensure compliance with the requirement that individuals who make decisions on appeals are individuals with clinical expertise in treating the member's condition. **HBN**'s appeals process attachment to the NABD stated that, if continuing services during the State fair hearing, the member must request the continuation within 10 calendar days of "this letter." Since the appeals process handout is attached to the NABD and not the appeal resolution letter, this statement is inaccurate and should be revised to clearly state that the State fair hearing (if requesting continuation of services) must be requested within 10 calendar days of the appeal resolution notice. **[Quality, Timeliness, and Access]**

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

For the standards reviewed in CY 2020–2021, the following opportunities for improvement were identified and resulted in required actions:

- Ensure all provider claims disputes are resolved within 30 calendar days, per their policies and procedures.
- Ensure that, going forward, if all CMS Adult Core Set and Child Core Set measures continue to be required, they appear in the workbooks and reports submitted to MLTC.
- Make a reasonable effort to ensure that acknowledgment letters for grievances and appeals are sent to members and providers within the required timeframe of 10 calendar days. This includes continuing to train staff on grievances and appeals policies and protocols for timely acknowledgment and following internal workflows and processes for processing grievances and appeals.

- Resolve each expedited appeal within the required timeframe of 72 hours after receipt and train appropriate staff on the processes and procedures related to resolution of expedited appeals.
- Submit proof of submission of Grievance and Appeal Logs to MLTC within the review period in question to satisfy requirement.

HBN reported engaging in the following required corrective actions:

- A root cause assessment was completed and an adjustment was made on October 15, 2020. A script placed a hold on the adjustment causing it not to go out timely. The script was corrected to no longer put adjustments in a hold status.
- Both Medicaid and CHIP populations were included in the survey and results stratified. The required performance measures were listed in the 2020 Quality Management Work Plan, 2020 Quality Management Program Evaluation, and the State required workbook. Also, CAHPS responses were stratified.
- The two Grievance Coordinators were coached. A refresher training was conducted for all the Grievance Coordinators. The training stressed the need to acknowledge and resolve grievances within the State SLA period. An email was sent to our internal providers reminding them of the need for routing cases timely to the Grievance department, stressing that that Grievance SLA with the State.
- Verified completion of timely response utilizing reporting tools. Education of timeliness for coordinator was completed to ensure the standard was being followed.
- Educated reporting staff on requirement. **HBN** further monitored the timeliness of reviews and reporting to ensure proof of submission within the required time.

HSAG determined that by conducting the above activities, **HBN** adequately addressed the CY 2020–2021 recommendations.

Validation of Network Adequacy

Results

HBN's provider data evaluation findings are presented in Table A-9. Twenty of 24 requested data fields were completed for all records. The only data fields missing for a substantial number of records were the county in which the provider's business servicing address was located (ProvCounty) and a text description of the provider's additional language spoken (Addl_Lang). Gray shading indicates that the percentage of values with a valid format or valid value was not assessed for that field.

Table A-9—Assessment of HBN's Provider Data Completeness and Validity

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
BusName**	The provider's business name, if applicable	100.0		
FName***	The first name of an individual provider	100.0		
LName***	The last name of an individual provider	100.0		
ProvID	A unique identification number assigned for a servicing or billing provider	100.0		
NPI	National Provider Identifier, a Health Insurance Portability and Accountability Act (HIPAA) standard unique identifier assigned to each health care provider	100.0	100.0	100.0
Sex***	The provider's gender	95.2	95.2	95.2
Address1	The first street address line for each provider/business servicing address	100.0		
City	The city of each provider/business servicing address	100.0		
State	The state abbreviation code for each provider/business servicing address	100.0	100.0	100.0
ZIP	The five-digit ZIP or postal code for each provider/business servicing address	100.0	100.0	100.0
County	The five-digit Federal Information Processing Standards (FIPS) code representing the state and county in which the servicing address is located	87.1	87.1	87.1
Phone	The telephone number associated with the servicing address at which the provider serves Heritage Health members	100.0	99.9	99.4
New_Pt	Indicator identifying whether the provider accepts new patients	100.0	100.0	100.0
Panel_Capacity	The maximum number of Heritage Health members that the provider will accept	100.0	100.0	
PCP_Flag	Indicator identifying if the provider is a primary care provider (PCP)	100.0	100.0	100.0
Alt_LangSpoken***	Indicator identifying whether the provider speaks a non-English language, including American Sign Language (ASL)	100.0	100.0	100.0
Prim_Lang***	Text description of the provider's primary language spoken, including English	100.0	100.0	

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
Addl_Lang***	Text description of the provider's additional language spoken	13.2	13.2	
Spec_cd1	Primary specialty of the provider/business	100.0		
Provtype1	Provider's primary provider type	100.0		
Txnmy_cd1	Primary provider taxonomy code of the provider/business—10-digit code	100.0	100.0	100.0
Degree***	Degree or certification attained, if available (e.g., MD, RN, LPC)	99.5		
Start_Date	The provider's MCE contract start date	100.0	100.0	100.0
End_Date****	The provider's MCE contract end date	0.0	0.0	0.0

[1] *Percent of Records Present* indicates that the MCE submitted a non-missing data value for the specified data field.
[2] *Percent of Records with Valid Format* indicates that the MCE's present data values aligned with the data format in the data request document.
[3] *Percent of Records with Valid Values* indicates that the MCE's present data values aligned with the allowable data values specified in the data request document.

Percentages are based on the total submitted records unless specified below:
** Only facilities included in calculation
*** Only individual practitioners included in calculation
**** Contract end dates for ongoing contracts were not evaluated.

Strengths

These results indicate that **HBN** collected the required critical data elements and provided near complete data in the requested format for most of the data elements. **[Quality and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for **HBN** to improve its data collection and submission processes to address potential issues in the future. DHHS has forwarded these recommendations to the plan for follow-up:

- **HBN** supplied HSAG with the network data used for the NAV analysis. Therefore, **HBN** should review its data practices to address deficiencies identified by HSAG. **[Quality]**
- **HBN** should conduct an in-depth internal investigation into HSAG's key data quality findings to identify the nature of the data issues that led to the findings and formulate a strategy for correcting these deficiencies:

- 86.8 percent of provider records lacked a text description indicating which non-English languages are spoken by the provider. Data regarding non-English languages spoken by providers is important information that members need to select among providers and may be useful for identifying potential language barriers to care for non-English-speaking members. **[Quality and Access]**
- 95.9 percent of **HBN**'s providers were associated with more than 10 physical service location addresses. This number of service locations per provider seems high, and may be indicative of errors in data that could impact provider directories and time and distance analyses. Accurate provider locations are critical information for future NAV activities. **[Quality and Access]**
- 12.9 percent of provider service location addresses were associated with County FIPS codes that did not align with the geocoded addresses. This misalignment could be indicative of errors in provider location data that might impact provider directories and time and distance analyses. **[Quality and Access]**

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

During CY 2020–2021, there were no quality improvement recommendations identified for the NAV activity. NAV activities for CY 2021–2022 will take into account the strengths and weaknesses identified in this preliminary analysis.

Validation of Performance Improvement Projects

Results

NTC submitted the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP for the CY 2021–2022 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission and an overall *Met* validation status for the resubmission. Table B-1 illustrates the validation scores.

Table B-1—2021–2022 PIP Validation Results for NTC

PIP Title	Type of Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Initial Submission	84%	89%	*Partially Met*
	Resubmission	89%	100%	*Met*

Table B-2 displays performance indicator results for **NTC**'s *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP.

Table B-2—Performance Indicator Results for NTC

PIP Performance Indicator	Baseline (1/1/2019 to 12/31/2019)		Remeasurement 1 (1/1/2020 to 12/31/2020)		Sustained Improvement
The percentage of members ages 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who received an antipsychotic medication who had a diabetes screening test during the measurement year.	N: 836 D: 1,020	81.96%	N: 866 D: 1,095	79.09%	*Not Assessed*

N–Numerator; D–Denominator

For the baseline measurement period, **NTC** reported that 81.96 percent of targeted members who were dispensed an antipsychotic medication received a diabetes screening test during the measurement year. For the first remeasurement period, **NTC** reported that 79.09 percent of targeted members who were dispensed an antipsychotic medication received a diabetes screening test during the measurement year. The results from the first remeasurement represented a decline of 2.87 percentage points from baseline indicator performance.

Interventions

For the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP, **NTC** used brainstorming and a fishbone diagram to identify barriers to improving performance indicator outcomes. To address identified barriers, **NTC** carried out the following interventions:

- Annual CM staff training on the HEDIS *SSD* measure and clinical practice guidelines (CPGs).
- Targeted telephonic and mailed outreach to members in the eligible population who are due for a diabetic screening.
- Email education for primary care and behavioral health care providers on the HEDIS *SSD* measure and CPGs.
- Targeted telephonic outreach to prescribing providers whose members are due for a diabetic screening test; outreach provided a report of members due for screening and offered additional CM assistance, as needed.

Strengths

The PIP validation findings suggest a thorough application of the PIP Design stage (steps 1 through 6). A methodologically sound design created the foundation for **NTC** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

In the Implementation stage (steps 7 and 8), **NTC** progressed to reporting performance indicator results from the first remeasurement (interim) period and initiated interventions linked to identified barriers to improvement. The MCO accurately reported performance indicator data for each measurement period. **NTC** conducted appropriate QI processes to identify barriers and deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement in the Implementation and Outcomes stages of the PIP. In the Implementation stage, HSAG was unable to replicate **NTC**'s reported statistical testing results comparing performance between the baseline and first remeasurement period. **[Quality]**

In the Outcomes stage, the first remeasurement results for the PIP performance indicator demonstrated a decline from baseline performance. **[Quality, Timeliness, and Access]**

To address identified opportunities for improvement, HSAG recommended the following for **NTC**:

- Ensure accurate and appropriate statistical testing is used to compare the results of each annual remeasurement to the baseline results, to determine if the performance indicator(s) demonstrated

statistically significant improvement. The MCO should request technical assistance with statistical testing from HSAG, as needed, to ensure appropriate statistical testing is completed and accurately reported. **[Quality]**

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

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

NTC reported to HSAG that the following EQR recommendations were identified during CY 2020–2021 by the previous EQRO:

- Include next steps for each PIP in the QI Work Plan, so that the MCO has a high-level framework to guide their actions for the subsequent project year.

NTC reported engaging in the following quality improvement initiatives to address the prior year's recommendations:

- The 2020 QI Program Evaluation that was reviewed December 2, 2020, Quality Assurance and Performance Improvement Committee (QAPIC) and submitted to the state in February 2021 incorporated the updated results through end of quarter 4 (Q4) 2020.
- The PIP next steps were added to the 2020 QI Work Plan which was submitted to the state in February 2021 and updated accordingly on a quarterly basis.

HSAG determined that by conducting the above activities, **NTC** adequately addressed the CY 2020–2021 recommendations. It should be noted that PIP scores assigned by the previous EQRO in CY 2020–2021 are not comparable to PIP scores assigned by HSAG in CY 2021–2022. HSAG used its own PIP scoring methodology for PIP validation in CY 2021–2022. In CY 2021–2022, HSAG's scope of work included validation of only the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP. HSAG provided technical assistance on the PCR PIP design to **NTC** in CY 2021–2022 and the MCO will submit the PCR PIP for the CY 2022–2023 validation cycle. HSAG will report validation findings and recommendations for the PCR PIP in the CY 2022–2023 technical report.

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated **NTC**'s IS capabilities for accurate HEDIS reporting. HSAG reviewed **NTC**'s FARs for its LO's assessment of IS capabilities assessments, specifically focused on those system aspects of **NTC**'s system that could have impacted the HEDIS Medicaid reporting set.

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

In accordance with NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures,* the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that **NTC**'s IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. **NTC** may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

The section that follows provides a summary of **NTC**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in Appendix E of this report.

Table B-3—Summary of Compliance With IS Standards for NTC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored.	The LO determined that **NTC** was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that **NTC** only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCO continually assess data completeness and take steps to improve performance. • The MCO effectively monitor the quality and accuracy of electronic submissions. • The MCO have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**NTC** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **NTC** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**NTC** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **NTC** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **NTC** reviewed all provider data received from delegated entities.
IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate.	**NTC** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
• Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for ECDS reporting met reporting requirements. • NCQA-certified eCQM data met reporting requirements.	**NTC** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in non-standard form that required PSV.
IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**NTC** was compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by **NTC**'s staff members. Data were verified for accuracy at each data merge point.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**NTC** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA HEDIS Certified Measures vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **NTC**. According to DHHS's required data collection methodology, the rates displayed in Table B-4 reflect all final reported rates in **NTC**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **NTC** may have received an "*NA*" designation for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table B-4—HEDIS Audit Results for NTC

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

Table B-5—NTC's HEDIS Measures Rates and Audit Results

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
Effectiveness of Care: Prevention and Screening		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	64.39% ★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	56.34% ★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	60.00% ★★★	***R***
CIS: Childhood Immunization Status—Combination 2	71.53% ★★★★	***R***
CIS: Childhood Immunization Status—Combination 3	69.10% ★★★★	***R***
CIS: Childhood Immunization Status—Combination 10	49.64% ★★★★★	***R***
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	74.94% ★★	***R***
LSC: Lead Screening in Children	69.97% ★★★	***R***
BCS: Breast Cancer Screening	47.94% ★★	***R***
CCS: Cervical Cancer Screening	63.16% ★★★★	***R***
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	26.96% ★	***R***
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	42.01% ★	***R***
CHL: Chlamydia Screening in Women—Total	32.17% ★	***R***
Effectiveness of Care: Respiratory Conditions		
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17 Years	71.04% ★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64 Years	63.24% ★★★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 65 and older	NA	***NA***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
CWP: Appropriate Testing for Pharyngitis—Total	69.77% ★★★	***R***
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	16.67% ★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	75.82% ★★★★★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	89.54% ★★★★★	***R***
AMR: Asthma Medication Ratio—Ages 5 to 11	81.51% ★★★★	***R***
AMR: Asthma Medication Ratio—Ages 12 to 18	73.47% ★★★★	***R***
AMR: Asthma Medication Ratio—Ages 19 to 50	65.84% ★★★★★	***R***
AMR: Asthma Medication Ratio—Ages 51 to 64	63.51% ★★★★★	***R***
AMR: Asthma Medication Ratio—Total	73.71% ★★★★★	***R***
Effectiveness of Care: Cardiovascular Conditions		
CBP: Controlling High Blood Pressure	63.75% ★★★★★	***R***
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	***NA***
Effectiveness of Care: Diabetes		
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	85.40% ★★★★	***R***
CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)[*]	44.28% ★★★	***R***
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	47.20% ★★★★	***R***
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.18% ★★★★	***R***
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.02% ★★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
Effectiveness of Care: Behavioral Health		
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.05% ★★	***R***
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	39.41% ★★★	***R***
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	46.33% ★★★★	***R***
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	61.05% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	48.11% ★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	71.64% ★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	35.24% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	55.87% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	40.52% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.45% ★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	48.36% ★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	65.37% ★★★★★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder Illness—7-Day Follow-Up—Total	28.31% ★★★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	45.18% ★★★	***R***
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	8.21% ★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	13.37% ★★★	***R***
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	80.29% ★★★★★	***R***
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	70.20% ★★★★	***R***
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	***NA***
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.11% ★★★★★	***R***
Effectiveness of Care: Overuse/Appropriateness		
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females[*]	0.70% ★★★	***R***
URI: Appropriate Treatment for URI—Ages 3 Months to 17 Years	87.51% ★★	***R***
URI: Appropriate Treatment for URI—Ages 18 to 64 Years	76.08% ★★★	***R***
URI: Appropriate Treatment for URI—Ages 65 Years and Older	NA	***NA***
URI: Appropriate Treatment for URI—Total	85.98% ★★	***R***
LBP: Use of Imaging Studies for Low Back Pain	76.94% ★★★★	***R***
HDO: Use of Opioids at High Dosage[*]	5.59% ★★★	***R***
Access/Availability of Care		
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17	34.07% ★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17	17.22% ★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 18 and Older	38.40% ★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 18 and Older	9.25% ★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	37.64% ★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	10.64% ★★★	***R***
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	76.89% ★★	***R***
PPC: Prenatal and Postpartum Care—Postpartum Care	73.24% ★★★	***R***
Utilization		
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.60% ★★★★	***R***
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.47% ★★★	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^	0.03 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^	0.01 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^	0.11 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^	0.21 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^	0.62 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^	0.36 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^	0.07 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^	0.21 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—15–44 Years—Female^	0.16 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^	0.18 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^	0.05 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^	0.01 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^	0.03 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^	0.38 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^	0.73 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^	0.79 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^	0.38 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^	0.84 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^	0.21 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^	0.82 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^	0.08 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^	0.43 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^	0.08 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^	0.58 NC	***R***
AMB: Ambulatory Care—Emergency Department Visits—Total^,*	40.37 ★★★★	***R***
AMB: Ambulatory Care—Outpatient Visits—Total^	314.72 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^*	6.90 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Total Inpatient—Total All Ages	4.59 NC	***R***
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Maternity—Total All Ages^*	5.73 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Maternity—Total All Ages	2.53 NC	***R***
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Surgery—Total All Age^*	1.16 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Surgery—Total All Ages	10.21 NC	***R***
*IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Medicine—Total All Ages^*	2.45 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Medicine—Total All Ages	4.68 NC	***R***
Risk Adjusted Utilization		
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	11.66% ★★	***R***
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	10.86% NC	***R***
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	1.07 NC	***R***
Measures Collected Using Electronic Clinical Data Systems		
BCS-E: Breast Cancer Screening	—	***NR***

^ Rate is reported per 1,000 member months rather than a percentage.
NC indicates that a comparison to the HEDIS MY 2020 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MCOs followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO.
** For this indicator, a lower rate indicates better performance.*
HEDIS MY 2020 Performance Levels represent the following percentile comparisons:
★★★★★ *= 75th percentile and above*
★★★★ *= 50th to 74th percentile*
★★★ *= 25th to 49th percentile*
★★ *= 10th to 24th percentile*
★ *= Below 10th percentile*

Table B-6—NTC's CMS Core Set Measure Rates

CMS Core Set Measures*	MY 2020 Rate
Adult Core Set Measures	
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder	33.20%
PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,000 Member Months)	2.72
Child Core Set Measures	
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^	31.32
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^	25.36
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 10 to 19^	24.15
AUD-CH: Audiological Diagnosis No Later than 3 Months of Age	0.00%
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17	0.42%

* The MCO's self-reported CMS Adult Core Set and Child Core Set measures were not audited and rates are presented for information only.
^ Rate is reported per 1,000 member months rather than a percentage.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* and *Cervical Cancer Screening* measure indicators were a strength for **NTC**. **NTC** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* rates demonstrate that children 2 years of age are receiving immunizations for disease prevention to help protect them against a potential life-threatening illness and the spread of preventable diseases at a time in their lives when they are vulnerable.[B-1,B-2] In addition, the *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 were receiving screening for one of the most common causes of cancer death in the United States. The effective screening and early detection of cervical cancer have helped reduce the death rate in this country.[B-3] **[Quality, Timeliness, and Access]**

B-1 Mayo Clinic. 2014. "Infant and Toddler Health Childhood Vaccines: Tough questions, straight answers. Do vaccines cause autism? Is it OK to skip certain vaccines? Get the facts on these and other common questions." Available at: http://www.mayoclinic.com/health/vaccines/CC00014. Accessed on: Oct 28, 2021.
B-2 Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief.
B-3 American Cancer Society. 2020. "Key Statistics for Cervical Cancer." Last modified January 12, 2021. Available at: https://www.cancer.org/cancer/cervicalcancer/about/key-statistics.html. Accessed on: Oct 28, 2021.

Effectiveness of Care: Respiratory Conditions Domain

All *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation* measure indicators were a strength for **NTC**. **NTC** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. These rates indicate that **NTC** is handling asthma appropriately as a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs for all stakeholders involved.[B-4] In addition, based on the rate, **NTC** providers are appropriately prescribed medication to prevent and help members control their COPD related to the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* indicators. **[Quality and Timeliness]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was also a strength for **NTC**. **NTC** for this measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. The rate indicates that **NTC** providers are handling the monitoring and controlling of members' blood pressure in helping to prevent heart attacks, stroke, and kidney disease. Providers can help manage members' blood pressure through medication, encouraging low-sodium diets, increased physical activity, and smoking cessation.[B-5] **[Quality]**

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for **NTC**. **NTC** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. According to NCQA (as cited by the CDC), proper management is needed to control blood glucose levels, reduce risk of complications, and extend members' lives. Care providers can help members by prescribing and instructing proper medication practices, dietary regimens, and proper lifestyle choices such as exercise and quitting smoking.[B-6] **[Quality]**

Effectiveness of Care: Behavioral Health Domain

NTC for the following measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark:

[B-4] Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Oct 28, 2021.

[B-5] National Committee for Quality Assurance. *Controlling High Blood Pressure*. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Oct 15, 2021.

[B-6] Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services.

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64, 30-Day Follow-Up—Ages 18 to 64, 7-Day Follow-Up—Total, and 30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

Based on these rates, **NTC** providers were able to follow up with children after being diagnosed with ADHD through the continuation of their treatment to ensure their medication levels were managed appropriately to help manage attention and impulsive disorders. Also, **NTC** providers were appropriately managing care for patients hospitalized or discharged after an ED visit for mental health issues, as they are vulnerable after release. Follow-up care by trained mental health clinicians is critical for successfully transitioning out of an inpatient setting as well as preventing readmissions. In addition, because members with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death.[B-7] **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Imaging Studies for Low Back Pain* measure was a strength for **NTC**. **NTC** for this measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates **NTC** members did not have an imaging study within 28 days of the diagnosis. Evidence has shown unnecessary imaging for low back pain does not improve outcomes and exposes members to harmful radiation and unnecessary treatment.[B-8] **[Quality]**

Access/Availability of Care Domain

The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17* measure indicator was a strength for **NTC**. **NTC** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates that adolescents 13 to 17 years of age-initiated treatment and had

[B-7] National Committee for Quality Assurance. *Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder*. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Oct 15, 2021.

[B-8] National Committee for Quality Assurance. *Use of Imaging Studies for Low Back Pain*. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 15, 2021.

two or more additional AOD services or MAT within 34 days of the initiation visit. **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator was also a strength for **NTC**. **NTC** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates children within the first 15 months of life were seen by a PCP in order to help influence and assess the early development stages of the child. **[Quality and Access]**

In addition, the *Ambulatory Care—Emergency Department Visits—Total* measure indicator was a strength for **NTC**. **NTC** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark, suggesting appropriate utilization of services.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total* and *Counseling for Nutrition—Total* measure indicators were a weakness for **NTC**. **NTC** for these measures, indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. According to NCQA (as cited by the American Heart Association), child obesity has more than doubled over the last three decades and tripled in adolescents.[B-9] HSAG recommended that DHHS work with **NTC** and its providers to strategize the best way to use every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. If the rate in children and adolescents receiving these services is identified to be related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for improved access to these services. **[Quality]**

The *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator was a weakness for **NTC**. **NTC** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. HSAG recommended that DHHS work with **NTC** and its providers to target improving adolescent vaccination rates. The ongoing COVID-19 pandemic is a reminder of the importance of vaccination. **[Quality]**

The *Breast Cancer Screening* measure was a weakness for **NTC**. **NTC** for this measure ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This rate indicates

[B-9] Centers for Disease Control and Prevention (CDC). 2013 "Adolescents and School Health: Childhood Obesity Facts." Available at: http://www.cdc.gov/healthyyouth/obesity/facts.htm. Accessed on: Oct 28, 2021; and American Heart Association. 2013. "Overweight in Children."

women were not getting screenings for early detection of breast cancer, which may result in less effective treatment and higher health care costs. HSAG recommended that **NTC** conduct a root cause analysis or focus study to determine why its female members are not receiving preventive screenings for breast cancer. DHHS and **NTC** could consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **NTC** should implement appropriate interventions to improve the performance. If the rate in women receiving these services is identified to be related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for improved access to these services. **[Quality, Timeliness, and Access]**

The *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were a weakness for **NTC**. **NTC** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications. This includes PID, infertility, and increased risk of becoming infected with HIV-1 Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[B-10] HSAG recommended that **NTC** providers follow up annually with sexually active members through any type of communication to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for **NTC**. **NTC** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. HSAG recommended that **NTC** conduct a root cause analysis for the *Appropriate Testing for Pharyngitis* measure indicator to determine why members are not being tested. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics.[B-11] If the low rate in members accessing these services is identified as related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure was a weakness for **NTC**. **NTC** for this measure ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment

[B-10] Meyers DS, Halvorson H, Luckhaupt S. 2007. "Screening for Chlamydial Infection: An Evidence Update for the U.S. Preventive Services Task Force." *Ann Intern Med* 147(2):135–42.

[B-11] Centers for Disease Control and Prevention. 2013. "Strep Throat: All You Need to Know." Available at: http://www.cdc.gov/Features/strepthroat/. Accessed on: Oct 28, 2021.

plan that may protect against worsening symptoms and decrease the number of exacerbations.[B-12] HSAG recommended that DHHS ensure **NTC** and its providers are aware of spirometry testing to help create a treatment plan for members with COPD. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

The *Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator was a weakness for **NTC**. **NTC** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This rate indicates that adult members 18 years of age an older with a diagnosis of major depression who were newly treated with antidepressant medication remained on this medication for at least 84 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy, and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year.[B-13, B-14] Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[B-15] **[Quality]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* and *Total* measure indicators were a weakness for **NTC**. **NTC** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommended that **NTC** conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[B-16] In addition, HSAG recommended that providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17*, *Initiation of AOD Treatment—Total—Ages 18 and Older*,

[B-12] National Committee for Quality Assurance. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*. Available at: https://www.ncqa.org/hedis/measures/use-of-spirometry-testing-in-the-assessment-and-diagnosis-of-copd/. Accessed on: Oct 15, 2021.

[B-13] National Alliance on Mental Illness. 2013. "Major Depression Fact Sheet: What is Major Depression?"

[B-14] Centers for Disease Control and Prevention. 2012. "Suicide Facts at a Glance 2012."

[B-15] National Committee for Quality Assurance. *Antidepressant Medication Management*. Available at https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Oct 15, 2021.

[B-16] National Committee for Quality Assurance. *Appropriate Treatment for Children with Upper Respiratory Infection*. Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-children-with-upper-respiratory-infection/. Accessed on: Oct 15, 2021.

Engagement of AOD Treatment—Total—Ages 18 and Older, and *Initiation of AOD—Total—Total* measure indicators were a weakness for **NTC**. **NTC** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce health care spending.[B-17,B-18, B-19] HSAG recommended that **NTC** work with its providers to ensure they are reaching members with identified substance use disorder (SUD) and to engage in follow-up treatment. **NTC** might consider working with providers to illustrate the time sensitivity of the measure requirements and ask providers about their strategies for engagement in treatment. **[Quality, Timeliness, and Access]**

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator was a weakness for **NTC**. **NTC** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Studies indicate that as many as 60 percent of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care, and made changes in their health and lifestyle habits.[B-20] Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[B-21] HSAG recommended that **NTC** work with its providers on best practices for providing ongoing prenatal care. This is especially important during COVID-19, as pregnant and recently pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women.[B-22] **[Quality, Timeliness, and Access]**

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—Observed Readmissions—Total* measure indicator was a weakness for **NTC**. **NTC** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. A "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased

B-17 National Institute on Drug Abuse (NIDA). (2018). How effective is drug addiction treatment? Available at: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment Accessed on: Oct 15, 2021.

B-18 Substance Abuse and Mental Health Services Administration (SAMHSA). "Medication Assisted Treatment (MAT)." Available at: https://www.samhsa.gov/medication-assisted-treatment. Accessed on: Oct 28, 2021.

B-19 National Committee for Quality Assurance. *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.* Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Oct 28, 2021.

B-20 Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Available at: https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf. Accessed on: Oct 28, 2021.

B-21 American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

B-22 Centers for Disease Control and Prevention. Investigating the Impact of COVID-19 during Pregnancy. Available at: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/special-populations/pregnancy-data-on-covid-19/what-cdc-is-doing.html. Accessed on: Oct 15, 2021.

mortality and higher health care costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.[B-23] HSAG recommended that **NTC** work with its providers to ensure diagnosis and treatment of members are complete and precise in order to improve readmission rates. **[Quality]**

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

During CY 2020–2021 the following EQR recommendations were identified:

- Develop interventions to specifically target performance for those HEDIS measures that are at or below the national Medicaid HMO average.
- Ensure that, going forward, if all CMS Adult Core Set and Child Core Set measures continue to be required, they appear in the workbooks and reports submitted to MLTC.

NTC reported engaging in the following quality improvement initiatives:

- The 2020 QI Program Evaluation that was reviewed December 2, 2020, QAPIC and submitted to the state in February 2021 incorporated the updated results through end of Q4 2020. The PIP next steps were added to the 2020 QI Work Plan which was submitted to the state in February 2021 and updated accordingly on a quarterly basis.
- Developed the following interventions and outreach campaigns to improve HEDIS rates with a goal to be at or above national average:
  - Care Gap list outreach.
  - P4P and Value Based Contracts with HEDIS measure reporting.
  - HEDIS guide updated on provider website.
  - Email campaigns.
  - Live and POM call campaigns.
  - Smart Start for Baby program.
  - Member and Provider Portals.
  - Care gaps addressed on telephonic 1:1s.
  - Website content/education updated for members.
  - Member education through website and email blasts.
  - Pfizer campaign outreaches for well child and immunization campaigns.
  - Worked with provider groups to fix supplemental data submissions related to capturing BMI percentile.
  - Data reports shared directly with provider groups.

[B-23] Boutwell A, Griffin F, Hwu S, et al. 2009. "Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions." Cambridge, MA. Institute for Healthcare Improvement.

  - Worked on establishing a text messaging campaign platform.
  - Implementation of vendors ExactCare and NESP to improve Pharmacy related HEDIS measures.
  - Provider resources & education: newsletters, email briefs, online education opportunities, HEDIS guide, town calls, value-based care meetings, provider relations representative; access to care gap lists through provider analytics related to member panel on provider portal.
  - Developed Case Management Rounds with designated high provider networks with Value Based Contracts. These rounds evaluate high utilization, high spend and / or high-risk related members. The Case Management rounds engage health system / provider clinic employees, Health Plan employees and / or other community related service partners. The goal is to identify opportunities to support the member and optimize their health status through collaboration.
  - "Where to Go for Care"– email messaging is sent to members via email how to use Urgent, ER care settings.
  - "Member Journey" email messaging that is sent over several weeks to new and existing members related to benefits, PCP, and other relevant member information.
  - Website on Emergency Care information: https://www.nebraskatotalcare.com/members/medicaid/resources/when-to-get-emergency-care.html
- Worked with Centene Corporate HEDIS team to ensure appropriate work requests, template revisions were made for ongoing Adult Core Set and Child Core Set measure submissions moving forward. Appropriate work requests for updates were submitted and these are required to Corporate DA team annually.
- CAHPS (Adult, Child [title 19 and 21], Child with CCC [title 19 and 21]) and HEDIS reports were submitted accordingly during state reporting time frames.

HSAG determined that by conducting the above activities, **NTC** adequately addressed the CY 2020–2021 recommendations.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table B-7—Summary of Scores for Each Standard for NTC

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
I. Enrollment and Disenrollment	7	7	7	0	0	100%
II. Member Rights and Confidentiality	6	6	4	2	0	67%
III. Member Information	22	22	19	3	0	86%

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
IV. Emergency and Poststabilization Services	12	12	12	0	0	100%
V. Adequate Capacity and Availability of Services	14	14	14	0	0	100%
VI. Coordination and Continuity of Care	9	9	9	0	0	100%
VII. Coverage and Authorization of Services	19	19	17	2	0	89%
VIII. Provider Selection and Program Integrity	16	16	16	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	75%
X. Practice Guidelines	3	3	3	0	0	100%
XI. Health Information Systems	6	6	6	0	0	100%
XII. Quality Assessment and Performance Improvement	6	6	6	0	0	100%
XIII. Grievance and Appeal System	26	26	15	11	0	58%
Totals*	**150**	**150**	**131**	**19**	**0**	**87%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Table B-8 presents the number of elements for each record type; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for CY 2021–2022.

Table B-8—Summary of NTC Scores for the CY 2021–2022 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Grievances	50	33	33	0	17	100%
Appeals	70	60	55	5	10	92%
Denials	60	50	45	5	10	90%
Totals*	**180**	**143**	**133**	**10**	**37**	**93%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Strengths

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

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

NTC achieved full compliance for the grievances record reviews. **[Quality, Timeliness, and Access]**

NTC achieved full compliance for the Enrollment and Disenrollment standard, demonstrating the MCE had policies and procedures that included all required provisions. Members are accepted into the health plan without restriction. Appropriate processes were in place related to member and MCE requests for disenrollment. **[Quality and Access]**

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

NTC achieved full compliance in the Adequate Capacity and Availability of Services standard, demonstrating **NTC** maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness** and **Access]**

NTC achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for their care management program. **NTC** implemented an extensive list of procedures to coordinate members services between setting of care and with community and social support agencies. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the Provider Selection and Program Integrity standard, demonstrating **NTC** had appropriate provider monitoring and processes to monitor, identify, plan, and mitigate fraud, waste and abuse. **NTC** had developed a compliance committee to ensure information sharing at the staff, management, and leadership levels. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the Practice Guidelines standard, demonstrating the MCE had a process in place to review and update clinical practice guidelines regularly. The guidelines passed through various individuals and committees for review. Guidelines were disseminated to all providers, and upon request to members and potential members. **[Quality]**

NTC achieved full compliance in the Health Information Systems standard, demonstrating the MCE had processes in place for how information is captured, processes, and stored in the MCE's data warehouse. **NTC**'s various data management programs afforded **NTC** the capability to capture and report on utilization patterns, claims, complaints, grievances, appeals, and provider and member demographic information. **[Quality and Access]**

NTC achieved full compliance in the Quality Assessment and Performance Improvement standard, demonstrating the MCE had maintained a well-developed, thorough, and continuous QAPI program. **NTC**'s program outlined activities such as performance improvement projects, performance measures, mechanisms to detect both underutilization and overutilization of services, and means of assessing the quality and appropriateness of care for members with special health care needs. **[Quality]**

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

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

NTC received a score of 67 percent in the Member Rights and Confidentiality standard. **NTC** must update its policies and procedures to include obtaining available and accessible health care services covered under the contract as a member right. Additionally, **NTC** must update its policies to ensure that member rights statements are inclusive of all protections outlined in the specific federal regulations listed in 42 CFR §438.100(a)(2) and (d). **[Access]**

NTC received a score of 86 percent in the Member Information standard. **NTC** must update its website information sheet and its website to include a notice that the member is informed that the information is available in paper form without charge upon request and is provided within five business days. Also, **NTC** must update its provider directories to include the website URLs for its providers. In addition, **NTC** must update the grievance and State fair hearing sections of its member handbook to include messaging that assistance is available in completing grievances and State fair hearing forms. Moreover, HSAG recommended that **NTC** take measures to ensure that its process for sending provider termination letters aligns with the timelines outlined in its policy. **[Access]**

NTC received a score of 89 percent in the Coverage and Authorization of Services standard. **NTC** must ensure that policies and procedures consistently address sending the member an NABD at the time of any adverse decision on a claim. **NTC** must also develop a process to ensure that the NABDs are sent within a reasonable time following the decision to deny the claim. These NABDs must meet the format and content requirements of NABDs for preservice determinations. In addition, **NTC** must develop a mechanism to ensure that NABDs sent to members are at a reading level so members may easily understand the content. **NTC** should ensure that letters are written at a 6.9 grade level, to the extent possible, as required by **NTC**'s contract with DHHS. Furthermore, HSAG recommended that when providers are notified of an overturn of the decision as a result of the reconsideration or peer-to-peer review, that members receive a copy of the notification, or an equivalent notification, as well. Since a resolution letter is not required for the informal processes and members do not receive the message of approval after they have received the NABD, they may be reluctant to schedule the care. Also, HSAG recommended that **NTC** remove the 45-calendar-day reference or align any resubmission of information with the 14-calendar-day extension time frame to make clear to staff members that awaiting additional

information from the provider may not delay the initial determination past 28 calendar days from the request for service (14 calendar days plus the 14-calendar-day extension). **[Timeliness and Access]**

NTC received a score of 75 percent in the Subcontractual Relationships and Delegation standard. **NTC** must ensure that all contracts and written arrangements (agreements) specify the following provisions: the State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or the determination of amounts payable under the MCE's contract with the State; the subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members; the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; if the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. **[Quality]**

NTC received a score of 58 percent in the Grievance and Appeal System standard. In applicable policies and documents, **NTC** must include either a definition of "adverse benefit determination," or a list of circumstances under which an NABD must be sent. Also, **NTC** must clarify its policy to state that members may file grievances with **NTC** orally and that there is no time limit for filing. HSAG recommended that internal communications with staff members include directions that while communicating with members regarding these types of complaints, staff members may alert members to the limitations if filing directly with the OCR, while communicating no **NTC** restrictions for filing grievances. In addition, **NTC** must develop a mechanism to ensure that, for each grievance that is resolved, the member receives a notice of resolution in writing in a format and language that may be easily understood by the member. HSAG recommended that a separate, more informal template to follow these grievances may be appropriate. Importantly, **NTC** must revise all applicable policies, procedures, and member and provider materials to clearly state that members may file an appeal orally or in writing. Furthermore, **NTC** must provide clarification within its policies, procedures, and member and provider materials by stating that **NTC** may extend the time frame for the resolution of appeals by up to 14 calendar days if: the member requests the extension; or the MCE shows (to the satisfaction of MLTC, *upon request*) that there is need for additional information and how the delay is in the member's interest. **NTC** must also ensure that the applicable policies include the provisions that **NTC** makes reasonable efforts to give the member prompt oral notice of the delay, and follows up within two calendar days with written notice of the reason for the delay. Written notice must inform the member of his or her right to file a grievance if he or she disagrees with the decision to extend the time frame. Additionally, **NTC** must develop a mechanism to ensure that appeal resolution notices clearly state the reason for the decision and are written in a manner and format that may be easily understood at a 6.9 grade reading level to the extent possible, as required by **NTC**'s contract with DHHS. **NTC** must clarify its policy to state that members may request a State fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination. In addition, the template letters provided did not include informing the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited review. **NTC** must ensure that if it denies a member's request to expedite the review of an

appeal request, it: transfers the appeal to the time frame for standard resolution; makes reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution; follows up within two calendar days with a written notice of the denial of expedition and informs the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. Also, **NTC** must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal. **NTC** must revise its applicable policies and related documents to remove the expiration of the authorization as an event that would trigger the end of continued services as well as remove the statement that the authorization having not yet expired is a condition of continuing services during the State fair hearing. Moreover, **NTC** must revise its provider manual to include and or correct the following information:

- Page 75 of the provider manual stated that an appeal may be filed at any time.
- The definition of "notice of adverse benefit determination" was missing the following elements added to the definition in the 2016 revisions:
  - The additional language within the first component of the definition, "requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit."
  - The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).
- Beneath the discussion of extending the time frame for resolution of appeals, the provider manual stated, "Nebraska Total Care will make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not wholly in favor of the member and shall follow-up within two calendar days with a written adverse benefit determination." This clause should be:
  - Make reasonable efforts to give the member prompt oral notice of the delay.
  - Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision.
- **NTC** must include that the notice denying an expedited appeal resolution will include the member's right to file a grievance if he or she disagrees with the decision to deny the expedited review.
- While the provider manual includes that services will be provided promptly and as expeditiously as the member's health condition requires, **NTC** must add that services must be provided no later than 72 hours from the date **NTC** receives notice reversing the determination.

The following recommendations were also provided to **NTC** in regard to the grievance and appeal standard:

- The Grievance and Appeal System policy indicated that members will be provided "further appeal rights." No appeal rights following a grievance exist. The grievance resolution letter, however, accurately provided the member with a second grievance review by **NTC**'s quality management staff members. HSAG recommended clarifying in policy that the second-level grievance review is not an appeal.

- HSAG found that **NTC** included a grievance and appeal form within the member handbook. HSAG recommended that **NTC** develop separate grievance an appeal forms to help members understand the specific processes and timelines when seeking to file either a grievance or an appeal.
- HSAG found that in the member handbook when referring to a grievance, **NTC** stated that grievances are related to any action by **NTC**. Given the association between the terms "action" and "adverse benefit determination," HSAG recommended that **NTC** revise this language to avoid potential confusion, since grievances may be filed about any matter other than an adverse benefit determination (previously known as, and sometimes still referred to as, an "action"). **[Quality, Timeliness, and Access]**

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

For the standards reviewed in CY 2020–2021, the following opportunities for improvement were identified and resulted in required actions:

- Communicate to providers (e.g., in the Provider manual or the provider portal) the process they have in place for in person complaints.
- Ensure provider appeals/claims disputes are resolved in accordance with the timelines reflected in **NTC**'s policies and procedures.

NTC reported engaging in the following required corrective actions:

- Communicated to providers, the change in process for in person complaints on the website, which can be found in the *For Providers* section of our website: https://www.nebraskatotalcare.com/providers/resources/grievance-process.html (content for in person submission process is at bottom of the page).
- Reviewed the appeals/claims dispute that had a finding outside of timely. **NTC** could not correct the actual file. Processes for claims appeal processing remain in place last year and **NTC** continues to work to meeting appeal processing within identified timeline.

HSAG determined that by conducting the above activities, **NTC** adequately addressed the CY 2020–2021 recommendations.

Validation of Network Adequacy

Results

NTC's provider data evaluation findings are presented in Table B-9. Ninety percent or more of all records contained values for 20 of 24 requested data fields. However, data were missing in more than 10 percent of records for the business name (BusName), provider ID number (ProvID), and provider degree

or certification (Degree) data fields. Gray shading indicates that the percentage of values with a valid format or valid value was not assessed for the field.

Table B-9—Assessment of NTC's Provider Data Completeness and Validity

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
BusName**	The provider's business name, if applicable	84.7		
FName***	The first name of an individual provider	100.0		
LName***	The last name of an individual provider	100.0		
ProvID	A unique identification number assigned for a servicing or billing provider	82.6		
NPI	National Provider Identifier, a HIPAA standard unique identifier assigned to each health care provider	100.0	99.5	99.5
Sex***	The provider's gender	99.9	99.9	99.9
Address1	The first street address line for each provider/business servicing address	100.0		
City	The city of each provider/business servicing address	100.0		
State	The state abbreviation code for each provider/business servicing address	100.0	100.0	100.0
ZIP	The five-digit ZIP or postal code for each provider/business servicing address	100.0	99.8	99.8
County	The five-digit FIPS code representing the state and county in which the servicing address is located	99.8	87.3	87.3
Phone	The telephone number associated with the servicing address at which the provider serves Heritage Health members	94.7	94.5	94.3
New_Pt	Indicator identifying whether the provider accepts new patients	99.6	99.6	99.6
Panel_Capacity	The maximum number of Heritage Health members that the provider will accept	98.7	98.7	
PCP_Flag	Indicator identifying if the provider is a primary care provider (PCP)	99.6	99.6	99.6
Alt_LangSpoken***	Indicator identifying whether the provider speaks a non-English language, including American Sign Language (ASL)	100.0	100.0	100.0

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
Prim_Lang***	Text description of the provider's primary language spoken, including English	99.9	99.9	
Addl_Lang***	Text description of the provider's additional language spoken	100.0	0.0	
Spec_cd1	Primary specialty of the provider/business	100.0		
Provtype1	Text description of provider's primary provider type	98.7		
Txnmy_cd1	Primary provider taxonomy code of the provider/business—10-digit code	99.5	99.5	99.5
Degree***	Degree or certification attained, if available (e.g., MD, RN, LPC)	88.2		
Start_Date	The provider's MCE contract start date	100.0	99.6	99.6
End_Date****	The provider's MCE contract end date	0.5	0.5	0.5

[1] *Percent of Records Present* indicates that the MCE submitted a non-missing data value for the specified data field.
[2] *Percent of Records with Valid Format* indicates that the MCE's present data values aligned with the data format in the data request document.
[3] *Percent of Records with Valid Values* indicates the MCE's present data values aligned with the allowable data values specified in the data request document.
Percentages are based on the total submitted records unless specified below:
** Only facilities included in calculation
*** Only individual practitioners included in calculation
**** Contract end dates for ongoing contracts were not evaluated.

Strengths

These results indicate that **NTC** collected the required critical data elements and provided fairly complete data in the requested format for most of the data elements. **[Quality and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for **NTC** to improve its data collection and submission processes to address potential issues in the future. DHHS has forwarded these recommendations to the plan for follow-up:

- **NTC** supplied HSAG with the network data used for the NAV analysis. Therefore, **NTC** should review its data practices to address deficiencies identified by HSAG. **[Quality]**

- **NTC** should conduct an in-depth internal investigation into HSAG's key data quality findings to identify the nature of the data issues that led to the unexpected findings and formulate a strategy for correcting these deficiencies:
  - 15.3 percent of records identified as facility records did not contain a business name. It is unclear whether this is a data quality issue. **[Quality]**
  - 17.4 percent of **NTC**'s servicing or billing providers contained no unique Provider ID, although 100 percent contained valid NPIs. **[Quality]**
  - 11.8 percent of **NTC**'s records did not include a provider's degree or certification. It is unclear whether this is a data quality issue. **[Quality]**
  - 16.7 percent of provider service location addresses contained a County FIPS code that was not located in Nebraska. MCEs should maintain complete and accurate data regarding provider service locations, which is critical for both provider directories and time and distance calculations. **[Quality and Access]**
  - 62.4 percent of **NTC**'s providers were associated with more than 10 physical service location addresses. This number of service locations per provider seems high, and may be indicative of errors in data that could impact provider directories and time and distance analyses. Accurate provider locations are critical information for future NAV activities. **[Quality and Access]**

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

During CY 2020–2021, there were no quality improvement recommendations identified for the NAV activity. NAV activities for CY 2021–2022 will take into account the strengths and weaknesses identified in this preliminary analysis.

Appendix C. United Healthcare Community Plan

Validation of Performance Improvement Projects

Results

UHCCP submitted the *Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications* PIP for the CY 2021–2022 validation cycle. The PIP received an overall *Met* validation status for the initial submission and the MCO chose not to resubmit the PIP. Table C-1 illustrates the validation scores.

Table C-1—2021–2022 PIP Validation Results for UHCCP

PIP Title	Type of Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications	Initial Submission	95%	100%	*Met*

Table C-2 displays data for **UHCCP**'s *Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications* PIP.

Table C-2—Performance Improvement Project Outcomes for UHCCP

Performance Indicator	Baseline (1/1/2019 to 12/31/2019)		Remeasurement 1 (1/1/2020 to 12/31/2020)		Sustained Improvement
The percentage of members ages 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	N: 765 D: 952	80.36%	N: 1,225 D: 1,506	81.34%	*Not Assessed*
The percentage of members ages 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who are newly prescribed an antipsychotic medication and were screened for diabetes within 2–4 months following the initial dispensing event.	N: 502 D: 765	65.62%	Discontinued		*Not Assessed*

N–Numerator; D–Denominator

For the baseline measurement period, **UHCCP** reported results for two study indicators. For the first performance indicator, the MCO reported that 80.36 percent of eligible members who were dispensed an antipsychotic medication had a diabetes screening test during the measurement year. For the second performance indicator, the MCO reported that 65.62 percent of eligible members who were newly prescribed an antipsychotic medication were screened for diabetes within two to four months of the initial dispensing event.

For the first remeasurement period, **UHCCP** reported results for the first performance indicator only. The MCO reported that the second performance indicator, which focused specifically on diabetes screenings for newly prescribed members, was discontinued after communication with NCQA suggested that reporting components for the indicator were considered outside the NCQA Allowable Adjustment Rules. For the first performance indicator, **UHCCP** reported that 81.34 percent of eligible members who were dispensed an antipsychotic medication had a diabetes screening test during the measurement year. Results from the first remeasurement demonstrated an increase of 0.98 percentage point from baseline; however, the increase was not statistically significant ($p = 0.5449$).

Interventions

For the *Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications* PIP, **UHCCP** reported using a fishbone analysis to identify barriers to improving performance indicator outcomes. To address the identified barriers, **UHCCP** carried out the following interventions:

- Provider training—bimonthly webinar trainings, emails, and letters—on the need for diabetes screening for members who are dispensed antipsychotic medication(s).
- Mental health provider training—bimonthly webinar trainings, emails, and letters—on the importance of informing other health care providers when a member is prescribed an antipsychotic medication to ensure appropriate care coordination and follow-up.
- Outreach by clinical coordinators to members who have been dispensed antipsychotic medications to identify and address barriers to scheduling and attending a diabetes screening appointment. Outreach was conducted face-to-face and telephonically and included education on the importance of diabetes screenings and appointment scheduling assistance.

Strengths

The PIP validation findings suggest **UHCCP** completed a thorough application of the PIP Design stage (steps 1 through 6). A sound design created the foundation for **UHCCP** to progress to subsequent PIP stages—collecting data and carrying out interventions that had the potential to positively impact performance indicator results and outcomes for the project. **[Quality]**

In the Implementation stage (steps 7 and 8), **UHCCP** progressed to reporting performance indicator results from the first remeasurement (interim) period and initiated interventions linked to identified barriers to improvement. The MCO accurately reported performance indicator data for each

measurement period and statistical testing results comparing performance between the two measurement periods. **UHCCP** conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunity for improvement in the Outcomes stage of the PIP. In the Outcomes stage, although the performance indicator demonstrated improvement from baseline to the first remeasurement, the improvement was not statistically significant. **[Quality, Timeliness, and Access]**

To address identified opportunity for improvement, HSAG recommended the following for **UHCCP**:

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

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

UHCCP reported to HSAG that the following EQR recommendations were identified during CY 2020–2021 by the previous:

- Improve PIP scores.

UHCCP reported engaging in the following quality improvement initiatives to address the prior year's recommendations:

- For the SSD PIP, **UHCCP** implemented the following:
  - Provider clinic/facilities outreach by CPCs to provide education on the need for diabetic screenings.
  - Member outreach to provide education on the need for diabetic screenings when on antipsychotic medications.
  - The OmniChannel Program focuses on HEDIS gap closure by outreaching to members based on their communication preference, i.e. Text, interactive voice response (IVR), Email.
  - Member education through quarterly Member Newsletters included:

  - The Spring 2021 *Health Talk* edition, article titled *Take charge: Prepare to see your provider*, encourages members to complete an annual wellness visit which is an important part in preventive healthcare as this is the time a PCP can perform needed screening/testing to identify any health conditions earlier.

- For the PCR PIP, **UHCCP** implemented the following:
  - Outreach to members while inpatient to:
    - Educate members on Care Management Program
    - Encourage members to engage in care management upon discharge
    - Provided assistance with post discharge needed services (if applicable) to avoid readmission
  - Member outreach post discharge to:
    - Encourage members to schedule a follow up visit with their provider
    - Provide assistance to post discharge barriers to care (transportation, obtaining ordered medications, etc.)
    - Complete a Transition of Care assessment to identify member knowledge of discharge instructions, identify and assist with any barriers to care
    - Complete medication reconciliation
    - Verify provider visit occurred
  - Member education through quarterly Member Newsletters included:
    - In Summer 2021 *Health Talk* edition, article titled *Follow-Up care: Know what to do after going home from the hospital*, the health plan educated on the importance of understanding instructions, making an appointment with a PCP for follow-up so has to avoid another visit to the hospital or ER.

The CY 2020–2021 recommendation, "Improve PIP scores," was made by a different EQRO previously contracted with DHHS. In CY 2021–2022, HSAG used its own PIP scoring methodology for PIP validation. PIP scores assigned by the previous EQRO in CY 2020–2021 are not comparable to PIP scores assigned by HSAG in CY 2021–2022; therefore, it is not possible to evaluate whether **UHCCP** improved PIP scores. While the activities reported by **UHCCP** appeared to support improved PIP scores, HSAG cannot definitively evaluate whether PIP scores improved since the PIP scoring methods were not comparable from the previous year to current year. Finally, HSAG's scope of work for the current year included validation of only the *Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications (SSD)* PIP. HSAG provided technical assistance on the PCR PIP design to **UHCCP** in CY 2021–2022 and the MCO will submit the PCR PIP for the CY 2022–2023 validation cycle. HSAG will report validation findings and recommendations for the PCR PIP in the CY 2022–2023 technical report.

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated **UHCCP**'s IS capabilities for accurate HEDIS reporting. HSAG reviewed **UHCCP**'s FARs for its LO's assessment of IS capabilities assessments, specifically focused on those system aspects of **UHCCP**'s system that could have impacted the HEDIS Medicaid reporting set.

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

In accordance with NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that **UHCCP**'s IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. **UHCCP** may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

The section that follows provides a summary of **UHCCP**'s key findings for each IS standard as noted in its FAR. A more in-depth explanation of the NCQA IS standards is provided in Appendix E of this report.

Table C-3—Summary of Compliance With IS Standards for UHCCP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry • Industry standard codes are required and captured. • Primary and secondary diagnosis codes are identified. • Nonstandard codes (if used) are mapped to industry standard codes. • Standard submission forms are used. • Timely and accurate data entry processes and sufficient edit checks are used. • Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored.	The LO determined that **UHCCP** was compliant with IS Standard 1.0 for medical services data capture and processing. The LO determined that **UHCCP** only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry • All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. • Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. • The MCOs continually assess data completeness and take steps to improve performance. • The MCOs effectively monitor the quality and accuracy of electronic submissions. • The MCOs have effective control processes for the transmission of enrollment data. • Vendors are regularly monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 2.0 for enrollment data capture and processing. The LO determined that **UHCCP** had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry • Provider specialties are fully documented and mapped to HEDIS provider specialties. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of practitioner data are checked to ensure accuracy. • Processes and edit checks ensure accurate and timely entry of data into the transaction files. • Data completeness is assessed and steps are taken to improve performance. • Vendors are regularly monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 3.0 for practitioner data capture and processing. The LO determined that **UHCCP** appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, **UHCCP** reviewed all provider data received from delegated entities.
IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight • Forms or tools used for MRR capture all fields relevant to HEDIS reporting. • Checking procedures are in place to ensure data integrity for electronic transmission of information. • Retrieval and abstraction of data from medical records are accurately performed. • Data entry processes, including edit checks, are timely and accurate.	**UHCCP** was compliant with IS Standard 4.0 for MRR processes. The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
• Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	
IS 5.0—Supplemental Data—Capture, Transfer, and Entry • Nonstandard coding schemes are fully documented and mapped to industry standard codes. • Effective procedures for submitting HEDIS-relevant information are in place. • Electronic transmissions of supplemental data are checked to ensure accuracy. • Data entry processes, including edit checks, are timely and accurate. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards. • Data approved for ECDS reporting met reporting requirements. • NCQA-certified eCQM data met reporting requirements.	**UHCCP** was compliant with IS Standard 5.0 for supplemental data capture and processing. The LO reviewed the HEDIS repository and observed that it contained all data fields required for HEDIS reporting. In addition, the LO confirmed the appropriate quality processes for the data sources and identified all supplemental data that were in non-standard form that required PSV.
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	**UHCCP** was compliant with IS Standard 6.0 for data pre-production processing. File consolidation and data extractions were performed by **UHCCP**'s staff members. Data were verified for accuracy at each data merge point.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2020 FAR Review
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	**UHCCP** was compliant with IS Standard 7.0 for data integration. The LO indicated that all components were met and that the MCO used an NCQA HEDIS Certified Measures vendor, Inovalon, Inc., for data production and rate calculation.

Results for Performance Measures

The tables below present the audited rates in the IDSS as submitted by **UHCCP**. According to DHHS's required data collection methodology, the rates displayed in Table C-4 reflect all final reported rates in **UHCCP**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **UHCCP** may have received an "*NA*" designation for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table C-4—HEDIS Audit Results for UHCCP

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

Table C-5—UHCCP's HEDIS Measure Rates and Audit Results

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
Effectiveness of Care: Prevention and Screening		
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total	75.43% ★★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	69.59% ★★★	***R***
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	65.69% ★★★	***R***
CIS: Childhood Immunization Status—Combination 2	80.78% ★★★★★	***R***
CIS: Childhood Immunization Status—Combination 3	78.59% ★★★★★	***R***
CIS: Childhood Immunization Status—Combination 10	54.74% ★★★★★	***R***
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	82.24% ★★★★	***R***
LSC: Lead Screening in Children	73.97% ★★★★	***R***
BCS: Breast Cancer Screening	63.77% ★★★★★	***R***
CCS: Cervical Cancer Screening	60.83% ★★★★	***R***
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	29.01% ★	***R***
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	39.96% ★	***R***
CHL: Chlamydia Screening in Women—Total	32.71% ★	***R***
Effectiveness of Care: Respiratory Conditions		
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17 Years	72.77% ★★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64 Years	59.87% ★★★	***R***
CWP: Appropriate Testing for Pharyngitis—Ages 65 and older	NA	***NA***
CWP: Appropriate Testing for Pharyngitis—Total	70.77% ★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.12% ★★★★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	67.07% ★★★	***R***
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	84.15% ★★★	***R***
AMR: Asthma Medication Ratio—Ages 5 to 11	79.72% ★★★★	***R***
AMR: Asthma Medication Ratio—Ages 12 to 18	73.62% ★★★★★	***R***
AMR: Asthma Medication Ratio—Ages 19 to 50	69.11% ★★★★★	***R***
AMR: Asthma Medication Ratio—Ages 51 to 64	68.64% ★★★★★	***R***
AMR: Asthma Medication Ratio—Total	74.05% ★★★★★	***R***
Effectiveness of Care: Cardiovascular Conditions		
CBP: Controlling High Blood Pressure	68.37% ★★★★★	***R***
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	***NA***
Effectiveness of Care: Diabetes		
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	92.21% ★★★★★	***R***
*CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	29.68% ★★★★★	***R***
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	59.12% ★★★★★	***R***
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.34% ★★★★★	***R***
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.78% ★★★★★	***R***
Effectiveness of Care: Behavioral Health		
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	63.93% ★★★★★	***R***
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	48.67% ★★★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	45.64% ★★★★	***R***
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	55.30% ★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	56.88% ★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	78.90% ★★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	44.43% ★★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	66.41% ★★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	***NA***
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	49.31% ★★★★★	***R***
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	71.24% ★★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	45.40% ★★★★	***R***
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	66.00% ★★★★★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder Illness—7-Day Follow-Up—Total	13.08% ★	***R***
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	30.00% ★★	***R***
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	8.30% ★★★	***R***
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	12.46% ★★★	***R***
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	81.33% ★★★★★	***R***
SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia	68.67% ★★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	73.53% ★★★★	***R***
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	81.13% ★★★★★	***R***
Effectiveness of Care: Overuse/Appropriateness		
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females[*]	0.51% ★★★★	***R***
URI: Appropriate Treatment for URI—Ages 3 Months to 17 Years	88.28% ★★	***R***
URI: Appropriate Treatment for URI—Ages 18 to 64 Years	78.08% ★★★	***R***
URI: Appropriate Treatment for URI—Ages 65 Years and Older	67.50% ★★★	***R***
URI: Appropriate Treatment for URI—Total	86.81% ★★★	***R***
LBP: Use of Imaging Studies for Low Back Pain	77.29% ★★★★	***R***
HDO: Use of Opioids at High Dosage[*]	7.23% ★★★	***R***
Access/Availability of Care		
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment— Total—Ages 13 to 17	33.18% ★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment— Total—Ages 13 to 17	15.91% ★★★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment— Total—Ages 18 and Older	34.66% ★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment— Total—Ages 18 and Older	8.23% ★★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment— Total—Total	34.44% ★	***R***
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	9.38% ★★★	***R***
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.05% ★★★	***R***
PPC: Prenatal and Postpartum Care—Postpartum Care	78.10% ★★★★	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
Utilization		
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.89% ★★★★★	***R***
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	70.35% ★★★	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^	0.02 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^	0.10 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^	0.00 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^	0.12 NC	***R***
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^	0.11 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^	0.60 NC	***R***
FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^	0.29 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^	0.06 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^	0.06 NC	***R***
FSP: Frequency of Selected Procedures— Hysterectomy, Vaginal—15–44 Years—Female^	0.21 NC	***R***
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^	0.09 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^	0.02 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^	0.01 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^	0.09 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^	0.35 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^	0.81 NC	***R***
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^	0.88 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^	0.46 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^	1.21 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^	0.16 NC	***R***
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^	0.84 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^	0.08 NC	***R***
FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^	0.17 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^	0.10 NC	***R***
FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^	0.19 NC	***R***
AMB: Ambulatory Care—Emergency Department Visits^,*	37.07 ★★★★	***R***
AMB: Ambulatory Care—Outpatient Visits^	326.46 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^	6.04 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Total Inpatient—Total All Ages	5.22 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Maternity—Total All Ages^	4.38 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Maternity—Total All Ages	2.36 NC	***R***

HEDIS Measure	MY 2020 HEDIS Rate	Audit Result
IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Surgery—Total All Age^	1.13 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Surgery—Total All Ages	10.22 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Discharges per 1,000 Member Months—Medicine—Total All Ages^	2.38 NC	***R***
IPU: Inpatient Utilization—General Hospital/Acute Care—Average Length of Stay—Medicine—Total All Ages	5.89 NC	***R***
Risk Adjusted Utilization		
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	8.34% ★★★★★	***R***
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.16% NC	***R***
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	0.75 NC	***R***
Measures Collected Using Electronic Clinical Data Systems		
BCS-E: Breast Cancer Screening	63.50% NC	***R***

^ Rate is reported per 1,000 member months rather than a percentage.
NC indicates that a comparison to the HEDIS MY 2020 National Medicaid Benchmarks is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MCOs followed the specifications, but the denominator was too small (<30) to report a valid rate.
** For this indicator, a lower rate indicates better performance.*
HEDIS MY 2020 Performance Levels represent the following percentile comparisons:
★★★★★ *= 75th percentile and above*
★★★★ *= 50th to 74th percentile*
★★★ *= 25th to 49th percentile*
★★ *= 10th to 24th percentile*
★ *= Below 10th percentile*

Table C-6—UHCCP's CMS Core Set Measure Rates

CMS Core Set Measures*	MY 2020 Rate
Adult Core Set Measures	
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder	51.75%
PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,000 Member Months)	1.73

CMS Core Set Measures*	MY 2020 Rate
Child Core Set Measures	
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^	52.75
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^	22.27
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 10 to 19^	20.89
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Total^	23.49
AUD-CH: Audiological Diagnosis No Later than 3 Months of Age	NR
CDF-CH: Screening for Depression and Follow-Up Plan—Ages 12 to 17	0.42%

* The MCO's self-reported CMS Adult Core Set and Child Core Set measures were not audited and rates are presented for information only.
^ Rate is reported per 1,000 member months rather than a percentage.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* and *Cervical Cancer Screening* measure indicators were a strength for **UHCCP**. **UHCCP** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 10* rates demonstrate that children 2 years of age are receiving immunizations for disease prevention to help protect them against the potential of a life-threatening illness and the spread of preventable diseases at a time in their lives when they are vulnerable.[C-1,C-2] In addition, the *Cervical Cancer Screening* rate demonstrates that women ages 21 to 64 were receiving screening for one of the most common causes of cancer death in the United States. The effective screening and early detection of cervical cancer have helped reduce the death rate in this country.[C-3] **[Quality, Timeliness, and Access]**

In addition, *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Lead Screening in Children,* and *Breast Cancer Screening* measure indicators were also a strength for **UHCCP**. **UHCCP** for all three measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator demonstrates that adolescents 13 years of age had one dose of the meningococcal

C-1 Mayo Clinic. 2014. "Infant and Toddler Health. Childhood Vaccines: Tough questions, straight answers. Do vaccines cause autism? Is it OK to skip certain vaccines? Get the facts on these and other common questions." Available at: http://www.mayoclinic.com/health/vaccines/CC00014. Accessed on: Nov 2, 2021.
C-2 Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief.
C-3 American Cancer Society. 2020. "Key Statistics for Cervical Cancer." Last modified January 12, 2021. Available at: https://www.cancer.org/cancer/cervicalcancer/about/key-statistics.html. Accessed on: Oct 28, 2021.

vaccine and one Tdap vaccine. The rate demonstrated by *Lead Screening in Children* shows children under 2 years of age are adequately receiving a lead blood test to ensure they are maintaining limited exposure to lead. Finally, the *Breast Cancer Screening* rate demonstrates women 50 to 74 years of age had at least one mammogram to screen for breast cancer in the past two years. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Respiratory Conditions Domain

All *Asthma Medication Ratio* and *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicators were a strength for **UHCCP**. **UHCCP** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. These rates indicate that **NTC** is handling asthma appropriately as a treatable condition, and managing this condition appropriately can save billions of dollars nationally in medical costs for all stakeholders involved.[C-4] In addition, **UHCCP** adult members 40 years of age and older are adequately receiving spirometry testing to confirm their COPD diagnosis. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for **UHCCP**. **UHCCP** for this measure ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. This rate indicates that **UHCCP** providers are handling the monitoring and controlling of members' blood pressure in helping to prevent heart attacks, stroke, and kidney disease. Providers can help manage members' blood pressure through medication, encouraging low-sodium diets, increased physical activity, and smoking cessation.[C-5] **[Quality]**

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care for Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for **UHCCP**. **UHCCP** for these measure indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. According to NCQA (as cited by the CDC), proper management is needed to control members' blood glucose levels, reduce risk of complications, and extend members' lives. Care providers can help members by prescribing and instructing proper medication practices, dietary regimens, and proper lifestyle choices such as exercise and quitting smoking.[C-6] **[Quality]**

[C-4] Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Oct 28, 2021.

[C-5] National Committee for Quality Assurance. *Controlling High Blood Pressure*. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Oct 15, 2021.

[C-6] Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services.

Effectiveness of Care: Behavioral Health Domain

UHCCP for the following measures indicators ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17, 30-Day Follow-Up—Ages 6 to 17, 7-Day Follow-Up—Ages 18 to 64, 30-Day Follow-Up—Ages 18 to 64, 7-Day Follow-Up—Total,* and *30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

Based on these rates, **UHCCP** providers were effectively treating adult members 18 years of age and older with a diagnosis of major depression by prescribing and helping them remain on antidepressant medication for at least 84 days (Acute Phase) and also for 180 days (Continuation Phase). **UHCCP** providers also were able to follow up with children diagnosed with ADHD through the initiation of their treatment to ensure their medication levels were managed appropriately to help manage attention and impulsive disorders. Also, **UHCCP** providers were appropriately managing care for patients hospitalized or discharged after an ED visit for mental health issues, as they are vulnerable after release. Follow-up care by trained mental health clinicians is critical for successfully transitioning out of an inpatient setting as well as for preventing readmissions. In addition, because members with SMI who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death.[C-7] **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Imaging Studies for Low Back Pain* and *Non-Recommended Cervical Cancer Screening in Adolescent Females* measures were a strength for **UHCCP**. **UHCCP** for these measures ranked at or

[C-7] National Committee for Quality Assurance. *Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder*. Available at: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/. Accessed on: Oct 15, 2021.

above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. The rate for *Use of Imaging Studies for Low Back Pain* indicates that **NTC** members did not have an imaging study within 28 days of the diagnosis. Evidence has shown unnecessary imaging for low back pain does not improve outcomes and exposes members to harmful radiation and unnecessary treatment.[C-8] As shown by the *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate, **UHCCP** providers were effectively not providing unnecessary cancer screening which can be potentially harmful to the patient and unwarranted. **[Quality]**

Access/Availability of Care Domain

The *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17* measure indicator was a strength for **UHCCP**. **UHCCP** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. This indicates that adolescents 13 to 17 years of age initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. **[Quality, Timeliness, and Access]**

The *Prenatal and Postpartum Care—Postpartum Care* measure indicator was also a strength for **UHCCP**. **UHCCP** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark. Studies indicate that as many as 60 percent of all pregnancy-related deaths could be prevented if women had better access to health care, received better quality of care, and made changes in their health and lifestyle habits.[C-9] Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[C-10] **[Quality, Timeliness, and Access]**

Utilization Domain

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator was also a strength for **UHCCP**. **UHCCP** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. This indicates children within the first 15 months of life were seen by a PCP in order to help influence and assess the early development stages of the child. **[Quality]**

In addition, the *Ambulatory Care—Emergency Department Visits—Total* measure indicator was a strength for **UHCCP**. **UHCCP** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 50th percentile benchmark, suggesting appropriate utilization of services.

[C-8] National Committee for Quality Assurance. *Use of Imaging Studies for Low Back Pain*. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 15, 2021.

[C-9] Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Available at: https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf. Accessed on: Oct 28, 2021.

[C-10] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—Observed Readmissions—Total* measure indicator was a strength for **UHCCP**. **UHCCP** for this measure indicator ranked at or above NCQA's HMO Quality Compass HEDIS MY 2020 75th percentile benchmark. A "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.[C-11] **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total* measure indicators were a weakness for **UHCCP**. **UHCCP** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications. This includes PID, infertility, and increased risk of becoming infected with HIV-1. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[C-12] HSAG recommended that **UHCCP** providers follow up annually with sexually active members through any type of communication to ensure members return for yearly screening. If the low rate of members accessing these services is identified as related to the COVID-19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Respiratory Conditions Domain

The *Appropriate Testing for Pharyngitis—Ages 3 to 17* measure indicator was a weakness for **UHCCP**. **UHCCP** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. HSAG recommended that **UHCCP** conduct a root cause analysis for the *Appropriate Testing for Pharyngitis* measure to determine why members are not being tested. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics.[C-13] If the low rate of members accessing these services is identified as related to the COVID-

[C-11] Boutwell A, Griffin F, Hwu S, et al. 2009. "Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions." Cambridge, MA. Institute for Healthcare Improvement.

[C-12] Meyers DS, Halvorson H, Luckhaupt S. 2007. "Screening for Chlamydial Infection: An Evidence Update for the U.S. Preventive Services Task Force." *Ann Intern Med* 147(2):135–42.

[C-13] Centers for Disease Control and Prevention. 2013. "Strep Throat: All You Need to Know." Available at: http://www.cdc.gov/Features/strepthroat/. Accessed on: Oct 28, 2021.

19 public health emergency, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers, to identify safe methods for ensuring ongoing access to these important services. **[Quality]**

Effectiveness of Care: Behavioral Health Domain

The *Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators were a weakness for **UHCCP**. **UHCCP** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This indicates members 13 years of age and older were not receiving adequate follow-up for a SUD after an acute hospitalization, residential treatment, or detoxification visits within seven or 30 days. HSAG recommended that **UHCCP** prioritize identifying interventions to ensure members are scheduled for and receive these critical follow-up services. For example, **UHCCP** could consider provider-focused interventions that start with analyzing the performance of individual provider groups. If **UHCCP** found that performance was being impacted by certain providers, **UHCCP** could consider performance-based incentives to help motivate providers to focus on improving access. **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years* measure indicator was a weakness for **UHCCP**. **UHCCP** for this measure indicator ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. This indicates that members with a diagnosis of URI did result in an antibiotic dispensing event. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG recommended that **UHCCP** conduct a root cause analysis to ensure providers are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[C-14] In addition, HSAG recommended that providers evaluate their noncompliant claims to ensure there were no additional diagnoses during the appointment that justify the prescription of an antibiotic. **[Quality]**

Access/Availability of Care Domain

The Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17, *Initiation of AOD Treatment—Total—Ages 18 and Older*, *Engagement of AOD Treatment—Total—Ages 18 and Older*, and *Initiation of AOD Treatment—Total—Total* measure indicators were a weakness for **UHCCP**. **UHCCP** for these measure indicators ranked below NCQA's HMO Quality Compass HEDIS MY 2020 25th percentile benchmark. Treatment, including MAT, in conjunction with counseling or other behavioral therapies has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce

[C-14] National Committee for Quality Assurance. *Appropriate Treatment for Children with Upper Respiratory Infection*. Available at: https://www.ncqa.org/hedis/measures/appropriate-treatment-for-children-with-upper-respiratory-infection/. Accessed on: Oct 15, 2021.

health care spending.[C-15, C-16, C-17] HSAG recommended that **UHCCP** work with its providers to ensure they are reaching members with identified SUD and to engage in follow-up treatment. **UHCCP** might consider working with providers to illustrate the time sensitivity of the measure requirements and ask providers about their strategies for engagement in treatment. **[Quality, Timeliness, and Access]**

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

During CY 2020–2021 the following EQR recommendations were identified:

- Develop interventions to specifically target performance for those HEDIS MY 2019 measures that are at or below the national Medicaid HMO average.
- Develop interventions for reported rates below the national Medicaid HMO averages for the following measures:
  - *Child/Adolescent BMI Assessment*
  - *Child/Adolescent Counseling for Nutrition*
  - *Child/Adolescent Counseling for Physical Activity*
  - *Lead Screening in Children*
  - *COPD Spirometry Testing*
  - *Pharmacotherapy Management of COPD—Systemic Corticosteroid*
  - *Appropriate Treatment for URI*
  - *Appropriate Pharyngitis Testing*
  - *Chlamydia Screening*
  - *Follow-up for ADHD Medication—Continuation and Maintenance Phase*
  - *Timeliness of Prenatal Care*
  - *Postpartum Exam*
  - *Well-Child Visits (3–6 Years)*
  - *Ambulatory Care—ED Visits/1,000 MM*

[C-15] National Institute on Drug Abuse (NIDA). (2018). How effective is drug addiction treatment? Available at: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment Accessed on: Oct 15, 2021.

[C-16] Substance Abuse and Mental Health Services Administration (SAMHSA). "Medication Assisted Treatment (MAT)." Available at: https://www.samhsa.gov/medication-assisted-treatment. Accessed on: Oct 28, 2021.

[C-17] National Committee for Quality Assurance. *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.* Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Oct 28, 2021.

UHCCP reported engaging in the following quality improvement initiatives:

- The following interventions were developed to specifically target performance for those HEDIS MY 2019 measures that were at or below the national Medicaid HMO average:
  - **UHCCP** Clinical Provider (CPCs) collaborated with the providers and/or clinics, providing updated member HEDIS compliance data via the Patient Care Opportunity Report (PCOR).
  - **UHCCP** CPCs conducted trainings via WebEx for providers that included education on all HEDIS measures, coding questions and our Path Guideline materials.
- The following interventions were developed for rates below the national Medicaid HMO average:
  - **UHCCP** CPCs conducted trainings via WebEx for providers that included education on the PPC measure, maternity program and applicable agreements.
  - **UHCCP** care management team and CPCs in coordination with provider offices, conducted outreach to members to remind members of needed care. These outreaches were structured to educate the member/guardian on the importance of completing the non-compliant HEDIS® measure, encourage them to schedule visits with their PCP and assist the member/guardian in making the appointment and/or scheduling transportation as needed.
  - **UHCCP** offered providers the opportunity to engage in Value Base Contracting to close gaps in care.
  - **UHCCP** Member Services utilizes Advocate4Me agents to address member gaps in care. When a member calls into Member Services for support the Advocate4Me agent will receive notification of any open gaps in care and assist the member in taking the appropriate next steps to close those gaps.
  - Automated HEDIS measure calls were made to remind members of needed care.
  - Postcards were mailed to members for a reminder of needed care.
  - Member Rewards incentive program rewards members with a gift card for obtaining needed services for selected measures.
  - Letters were included in Welcome Packets to new members to encourage members seek preventive care.
  - The OmniChannel Program focuses on HEDIS gap closure by outreaching to members based on their communication preference, i.e. IVR, Email, Texts if member opts in.
  - Pharmacy manages the RetroDUR program for gaps in care to optimize the use of longer-term controller medications (LTCMs) as recommended and promote the appropriate use of short-acting beta-agonists (SABAs) in Chronic Obstructive Pulmonary Disease (COPD).
  - COPD pharmacotherapy management is included in the Medication Therapy Management (MTM) program.
  - Quality Reference Guide updated and posted on the provider website to help providers better understand the specifications for many of the quality measurement programs and tools used to address care opportunities www.uhcprovider.com/path .
  - **UHCCP** Care Management team makes daily calls to members who have utilized the Emergency Room for care. The Care management team educates the member on: locations of

emergent clinics vs ER usage, trouble shoots with the member for root causes of utilizing the ER, helps members make PCP appointments and transportation arrangements.

- **UHCCP** initiated a new pregnant member rewards card for moms who see an OB/GYN or PCP provider within the first trimester of the pregnancy or within 42 days of becoming a member of **UHCCP**.
- Maternity program enhancements. Health Services has implemented the following to improve performance in the pregnancy prenatal/postpartum measures:
  - Fall 2020 added additional maternity staff to both High Risk and Healthy pregnancy programs. This has increased the volume of outreaches and education provided to **UHCCP** members.
  - BCRT (Blended Census Reporting Tool) report: January 2021 maternity team utilizing the BCRT report to identify pregnant members who have delivered and need outreach reminders for postpartum care follow up visits. The resulting calls included educate on postpartum provider visit importance and assist members with any barriers they may have to attend that appointment.
  - February 2021 utilization of Maternity Member Assignment Report- (this report identifies members from 834 file with a pregnancy indicator and members that have a new pregnancy program line added). All identified members are assigned to maternity staff. Benefit: identification of pregnant members earlier, maternity team assigned will receive ER notification or hospitalization alerts prompting outreach to the pregnant member.
  - All Team Maternity Collaboration monthly meeting started April 2021-purpose: data driven, actionable collaboration across departments to improve pregnancy outcomes through provider, community, member engagement and education.
  - Pharmacy medication report started May 2021: the report is utilized to identify potential pregnant members through filling prenatal and anti-nausea medications. Members that are identified are assigned to maternity staff for initial outreach. Benefit is early identification and earlier outreaches by maternity staff.
- Behavioral Health focused interventions:
  - Educated behavioral health practitioners through an educational email blast "Treatment and Follow-Up for Children Prescribed ADHD Medication". Providers were targeted for having treated one or more children/ adolescents diagnosed with ADHD within the past 12 months. The email content included ADHD best treatment practices, the measure specifications and practitioner resources.
  - Educated medical practitioners via 'Behavioral Health Toolkit for Medical Providers' page on the network website posting
  - Educated parents of members via ADHD information and resources on the member website.
  - Educated **UHCCP** medical practitioners via provider newsletter article "Diagnosis and Treatment of ADHD" that includes information about assessment scales, online resources and includes the ADD HEDIS measure details.
  - Educated **UHCCP** medical practitioners via provider newsletter article "Online Behavioral Health Resources" that includes resource for treating attention-deficit/hyperactivity disorder

(ADHD), including assessment tools, behavioral health support and referral information, and a link to the behavioral health Prevention Center.

- Educated **UHCCP** medical practitioners via UnitedHealthcare's Administrative Guide for Physicians and Facilities, which includes a section titled "Important Behavioral Health Information." Content includes information about behavioral health programs, describing behavioral health services, how to refer to a behavioral provider, ADHD, Preventive Health Programs available to practitioners and their members, and the importance of collaboration between primary physicians and behavioral health practitioners.
- Posted document on behavioral health network website in Behavioral Health Toolkit for Medical Providers listing definitions of various behavioral health HEDIS measures as well as best practice tips for succeeding with each measure.
- Promoted provider website redesign of "Clinical Tools and Quality Measures Toolkit for Behavioral Providers" and updated materials in the Provider Network Newsletter Network Notes

– Meetings with the top 24 **UHCCP** OB providers in Nebraska were conducted with discussions around the HEDIS metrics as part of our maternity push.
– Ad hoc meetings with Federal Qualified Health Centers (FQHC) on targeted HEDIS measures examples: Chlamydia to support gap closure and sexually transmitted disease measures. Additionally, **UHCCP** met with a Pediatric partner to discuss their weight and wellness clinic and how to impact the measure utilizing their electronic medical record (EMR) system/specific documentation.
– A meeting with a large PCP provider on readmissions with a focused look at members with CHF and COPD readmissions. This provider has entered into an Accountable Care Organization agreement.
– UnitedHealthcare has highly sophisticated processes for Data collection. The complexities of the data exchanges present new challenges each year. For 2020 and 2021, the pandemic pushed the providers and **UHCCP** plan forward in the realm of close collaboration and electronic data exchange. That included **UHCCP** incentivizing providers via:
  - Direct EMR access.
  - Leveraging technology for data exchange between **UHCCP** and provider EMR's via certified Aggregators.
  - Custom Early pregnancy detection reporting, shifting the administrative burden from the provider to the MCO's and let the provider focus on care of the member.
  - Collaboration between health plan analytics and Providers Analytics team for absorbing Member level data.
  - Leveraging NESIIS (immunization registry) for the entire **UHCCP** Medicaid population.
  - **UHCCP** anticipates that the advances made in 2020 and 2021 will be built upon to gain further efficiencies.
– Member education through quarterly Member Newsletters included:

- In the Summer 2020 Health Talk edition, article titled Oh, baby! Baby Block™ becomes part of Healthy First Steps, the health plan provided information to our membership on the Healthy First Steps maternity program. This program provides the member with pregnancy related educational resources and case management which includes material on the importance of seeking timely prenatal and postpartum care services.
- In the Fall 2020 Health Talk edition, articles titled Take care of your mental health and Telehealth visits, discusses the importance of properly managing mental health conditions including understanding and obtaining needed medications.
- In the Winter 2021 Health Talk edition, article titled Stay on schedule, encourages members to seek preventive care services for children such as meeting with their primary care provider (PCP) to receive needed vaccines. Education is provided on the importance of receiving these vaccines during the COVID-19 pandemic and provided tips to safely navigate the healthcare system during the pandemic.
- The Spring 2021 Health Talk edition, article titled Take charge: Prepare to see your provider, encourages members to complete an annual wellness visit which is an important part in preventive healthcare as this is the time a PCP can perform needed screening/testing to identify any health conditions earlier.
- In Summer 2021 Health Talk edition, article titled Prevention is the best medicine, the health plan educated on the importance of preventive health screenings and testing. The article provides instructions on how and when members should make the necessary appointments with their PCP.
- In Summer 2021 Health Talk edition, article titled Follow-Up care: Know what to do after going home from the hospital, the health plan educated on the importance of understanding instructions, making an appointment with a PCP for follow-up so has to avoid another visit to the hospital or ER.

– Provider education through the Network Bulletin included:

- August 2020, Network Bulletin, an article Accessing Member Rosters Now Online provided education on how providers can access their member rosters online and obtain HEDIS information on their member population.

HSAG determined that by conducting the above activities, **UHCCP** adequately addressed the CY 2020–2021 recommendations.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table C-7—Summary of Scores for Each Standard for UHCCP

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
I. Enrollment and Disenrollment	7	7	6	1	0	86%
II. Member Rights and Confidentiality	6	6	6	0	0	100%
III. Member Information	22	22	18	4	0	82%
IV. Emergency and Poststabilization Services	12	12	12	0	0	100%
V. Adequate Capacity and Availability of Services	14	14	14	0	0	100%
VI. Coordination and Continuity of Care	9	9	9	0	0	100%
VII. Coverage and Authorization of Services	19	19	17	2	0	89%
VIII. Provider Selection and Program Integrity	16	16	15	1	0	94%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	100%
X. Practice Guidelines	3	3	3	0	0	100%
XI. Health Information Systems	6	6	6	0	0	100%
XII. Quality Assessment and Performance Improvement	6	6	6	0	0	100%
XIII. Grievance and Appeal System	26	26	24	2	0	92%
Totals*	**150**	**150**	**140**	**10**	**0**	**93%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Table C-8 presents the number of elements for each record type; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for CY 2021–2022.

Table C-8—Summary of UHCCP Scores for the CY 2021–2022 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Grievances	50	40	40	0	10	100%
Appeals	70	58	58	0	12	100%
Denials	60	50	47	3	10	94%
Totals*	**180**	**148**	**145**	**3**	**32**	**98%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Strengths

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

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

UHCCP achieved full compliance for the grievances and appeals record reviews. **[Quality, Timeliness, and Access]**

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

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

UHCCP achieved full compliance for the Adequate Capacity and Availability of Services standard, demonstrating **UHCCP** maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness** and **Access]**

UHCCP achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for their care management program. **UHCCP** implemented an extensive

list of procedures to coordinate members services between setting of care and with community and social support agencies. **[Quality, Timeliness, and Access]**

UHCCP achieved full compliance in the Subcontractual Relationships and Delegation standard, demonstrating the MCE had proper oversight and management with contracted vendors. **[Quality]**

UHCCP achieved full compliance in the Practice Guidelines standard, demonstrating the MCE had a process in place to review and update clinical practice guidelines regularly. **[Quality]**

UHCCP achieved full compliance in the Health Information Systems standard, demonstrating the MCE had processes in place for how information is captured, processes, and stored in the MCE's data warehouse. **[Quality and Access]**

UHCCP achieved full compliance in the Quality Assessment and Performance Improvement standard, demonstrating the MCE had maintained a well-developed, thorough, and continuous QAPI program. **UHCCP**'s program outlined activities such as performance improvement projects, performance measures, mechanisms to detect both underutilization and overutilization of services, and means of assessing the quality and appropriateness of care for members with special health care needs. **[Quality]**

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

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

UHCCP received a score of 86 percent in the Enrollment and Disenrollment standard. **UHCCP** must revise the policy to accurately state when the MCO may and may not consider a request for disenrollment from the plan. **[Quality and Access]**

UHCCP received a score of 82 percent in the Member Information standard. **UHCCP** must update its member handbook, welcome materials, provider directory, and preferred drug list to include a tagline with all required information. HSAG recommended including this information in one statement which is placed in a prominent location in the handbook (i.e., within the first few pages). Additionally, **UHCCP** must update the Member Welcome Materials policy and delegate agreements to ensure that the member will receive requested written information within five business days of the request. Member information materials such as the Getting Started Guide or member handbook must also be updated (wherever **UHCCP** deems appropriate) to inform the member of this right to request and receive written materials within five business days of the request. Importantly, **UHCCP** must update materials that are sent to the member within 10 business days of enrollment to include all required information about printed materials, and HSAG recommended including a more direct link to the member handbook. Moreover, **UHCCP** must update the member handbook to provide accurate information regarding the grievance, appeal, and State fair hearing procedures and time frames. **[Access]**

UHCCP received a score of 89 percent in the Coverage and Authorization of Services standard. **UHCCP** must ensure that initial requests for service considered expedited requests are processed, with determination made and notification sent, within 72 hours. In addition, HSAG recommended that when providers are notified of an overturn of the decision as a result of the reconsideration or peer-to-peer review, that members receive a copy of the notification, or an equivalent notification, as well. Since a resolution letter is not required for the informal processes and a member does not receive the message of approval after they have received the NABD, they may be reluctant to schedule the care. **[Timeliness and Access]**

UHCCP received a score of 94 percent in the Provider Selection and Program Integrity standard. **UHCCP** must describe in policy and procedure any processes for provider retention. **[Quality, Timeliness, and Access]**

UHCCP received a score of 92 percent in the Grievance and Appeal System standard. **UHCCP** must revise policies, procedures, and all applicable documents to clearly inform members, staff, and providers that a written appeal is not required and that members may file appeals orally with no further follow-up required. Furthermore, **UHCCP** must change its applicable policies and related documents to remove the expiration of the authorization as an event that would trigger the end of continued services as well as remove the statement that a condition of continuing services during the State fair hearing is the authorization having not yet expired. In addition, **UHCCP** must review its member-specific communications and applicable policies to ensure accuracy of depicting when the request for a State fair hearing must be filed. Additionally, given potential misunderstanding of the differences between a grievance and an appeal and the processes use to resolve each, HSAG recommended that **UHCCP** develop separate forms for members to use for submitting a grievance and an appeal. Also, HSAG recommended that **UHCCP** review this process and remind physicians that the narrative added into the system must be easy for members to understand. In addition, HSAG recommended that this be presented in policy and member information as such. While **UHCCP**'s policies and procedures and information within the provider manual clearly stated this is prohibited, the Additional Rights attachment to the appeal resolution letter stated that the member or provider acting on behalf of the member could request continued services during the State fair hearing. During the interview, staff indicated this to be an oversight when materials were updated. HSAG recommended that **UHCCP** update this attachment as soon as feasible. **UHCCP**'s provider manual included all required information to inform providers about the Medicaid and CHIP member grievance and appeal system. HSAG does, however, recommend that **UHCCP** add that if the member requests a State fair hearing with the request for continuing benefits during the hearing, both the request for continuation and the request for a hearing are due within 10 days following the appeal resolution. **[Quality, Timeliness, and Access]**

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

For the standards reviewed in CY 2020–2021, the following opportunities for improvement were identified and resulted in required actions:

- Ensure timely resolution of provider complaints, according to **UHCCP** policies (which state 30 days). Provider's right to file in-person complaints should be communicated in the provider manual.

UHCCP reported engaging in the following required corrective actions:

- Reviewed the provider grievance case identified in the audit and has implemented a new process for tracking and monitoring provider grievance inventory to prevent similar errors in the future. Based on review of provider grievances through July 31, 2021 all provider grievances were compliant to the 30-day turnaround. Also, **UHCCP** updated the Nebraska 2021 Care Provider Manual to include Provider's right to file in-person complaint in the Provider Grievance Section.

HSAG determined that by conducting the above activities, **UHCCP** adequately addressed the CY 2020–2021 recommendations.

Validation of Network Adequacy

Results

UHCCP's provider data evaluation findings are presented in Table C-9. Ninety percent or more of all records contained values for 20 of 24 requested data fields. However, data were missing in more than 90 percent of records in the data fields asking for a text description of the provider's primary language (Prim_Lang), a text description of additional languages spoken (Addl_Lang), and provider type (ProvType1).

Table C-9—Assessment of UHCCP's Provider Data Completeness and Validity

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
BusName**	The provider's business name, if applicable	100.0		
FName***	The first name of an individual provider	95.2		
LName***	The last name of an individual provider	95.2		
ProvID	A unique identification number assigned for a servicing or billing provider	100.0		
NPI	National Provider Identifier, a HIPAA standard unique identifier assigned to each health care provider	99.8	99.8	99.8
Sex***	The provider's gender	93.3	93.3	93.3
Address1	The first street address line for each provider/business servicing address	100.0		
City	The city of each provider/business servicing address	100.0		
State	The state abbreviation code for each provider/business servicing address	100.0	100.0	100.0

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
ZIP	The five-digit ZIP or postal code for each provider/business servicing address	100.0	100.0	100.0
County	The five-digit FIPS code representing the state and county in which the servicing address is located	100.0	100.0	100.0
Phone	The telephone number associated with the servicing address at which the provider serves Heritage Health members	100.0	100.0	99.9
New_Pt	Indicator identifying whether the provider accepts new patients	91.0	91.0	91.0
Panel_Capacity	The maximum number of Heritage Health members that the provider will accept	95.5	95.5	
PCP_Flag	Indicator identifying if the provider is a primary care provider (PCP)	99.9	99.9	99.9
Alt_LangSpoken***	Indicator identifying whether the provider speaks a non-English language, including American Sign Language (ASL)	98.1	98.1	98.1
Prim_Lang***	Text description of the provider's primary language spoken, including English	0.0	0.0	
Addl_Lang***	Text description of the provider's additional language spoken	7.3	7.3	
Spec_cd1	Primary specialty of the provider/business	92.8		
Provtype1	Text description of provider's primary provider type	7.2		
Txnmy_cd1	Primary provider taxonomy code of the provider/business—10-digit code	96.2	96.2	96.2
Degree***	Degree or certification attained, if available (e.g., MD, RN, LPC)	95.2		
Start_Date	The provider's MCE contract start date	100.0	100.0	99.1
End_Date****	The provider's MCE contract end date	0.0	0.0	0.0

[1] *Percent of Records Present* indicates that the MCE submitted a non-missing data value for the specified data field.

[2] *Percent of Records with Valid Format* indicates that the MCE's present data values aligned with the data format in the data request document.

[3] *Percent of Records with Valid Values* indicates that the MCE's present data values aligned with the allowable data values specified in the data request document.

Percentages are based on the total submitted records unless specified below:

** Only facilities included in calculation

*** Only individual practitioners included in calculation

**** Contract end dates for ongoing contracts were not evaluated.

Strengths

These results indicate that **UHCCP** collected the required critical data elements and provided fairly complete data in the requested format for most of the data elements. **[Quality and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for **UHCCP** to improve its data collection and submission processes to address potential issues in the future. DHHS has forwarded these recommendations to the plan for follow-up:

- **UHCCP** supplied HSAG with the network data used for the NAV analysis. Therefore, **UHCCP** should review its data practices to address deficiencies identified by HSAG. **[Quality]**
- **UHCCP** should conduct an in-depth internal investigation into HSAG's key data quality findings to identify the nature of the data issues that led to the findings and formulate a strategy for correcting these deficiencies:
  - 6.7 percent of provider records contained no gender data. MCEs should maintain complete and accurate data regarding provider gender, as it may affect access to care for some members requiring a provider with a specific gender. **[Quality and Access]**
  - 9.0 percent of **UHCCP**'s records lacked an identifier indicating whether the provider accepts new patients, which is critical to member selection of providers. **[Access]**
  - 7.2 percent of provider records contained a text description of the provider's primary specialty, which is critical to member selection of providers. While HSAG is confident that **UHCCP** has that data, it was not provided in the format requested and therefore could not be measured in this analysis. **[Quality and Access]**
  - 92.8 percent of provider records contained no entries in the provider type data field. While HSAG is confident that **UHCCP** has that data, it was not provided in the format requested and therefore could not be measured in analysis. **[Quality and Access]**
  - 6.2 percent of provider service location addresses could not be standardized to a valid postal service address. MCEs should maintain complete and accurate data regarding provider service locations. **[Quality and Access]**
  - 98.1 percent of provider records contained alternative-language data, but none of the reported provider records contained the requested text description of the primary language spoken (Prim_Lang) and 7.3 percent provided data on which additional language is spoken (Addl_Lang). Data regarding primary languages spoken by providers are important for identifying potential language barriers to care for members. While HSAG is confident that **UHCCP** has that data, it was not provided in the format requested and therefore could not be measured in this analysis. **[Quality and Access]**

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

During CY 2020–2021, there were no quality improvement recommendations identified for the NAV activity. NAV activities for CY 2021–2022 will take into account the strengths and weaknesses identified in this preliminary analysis.

Appendix D. Managed Care of North America, Inc.

Validation of Performance Improvement Projects

Results

MCNA submitted the *Preventive Dental Service* PIP for the CY 2021–2022 validation cycle. The PIP received an overall *Met* validation status for both the initial submission and resubmission. Table D-1 illustrates the validation scores.

Table D-1—2021–2022 PIP Validation Results for MCNA

PIP Title	Type of Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Preventive Dental Service	Initial Submission	86%	100%	*Met*
	Resubmission	90%	100%	*Met*

Table D-2 displays performance indicator results for **MCNA**'s *Preventive Dental Visit* PIP.

Table D-2—Performance Indicator Results for MCNA

PIP Performance Indicators	Baseline (1/1/2018 to 12/31/2018)		Remeasurement 1 (1/1/2019 to 12/31/2019)		Remeasurement 2 (1/1/2020 to 12/31/2020)		Sustained Improvement
1. Percent of members 1–20 years of age who received at least one preventive dental service during the measurement year.	N: 99,301 D: 181,771	54.63%	N: 99,591 D: 180,131	55.29%	N: 87,040 D: 180,829	48.13%	Not Achieved
2. Percent of members 21 years of age or older who received at least one preventive dental service during the measurement year.	N: 19,736 D: 93,929	21.01%	N: 19,281 D: 93,185	20.69%	N: 20,103 D: 95,277	21.10%	*Not Assessed*

PIP Performance Indicators	Baseline (1/1/2018 to 12/31/2018)		Remeasurement 1 (1/1/2019 to 12/31/2019)		Remeasurement 2 (1/1/2020 to 12/31/2020)		Sustained Improvement
3. Percent of members 1–20 years of age who received at least two preventive dental services six months apart during the measurement year.	N: 37,089 D:136,779	27.12%	N: 38,819 D: 136,437	28.45%	N: 27,464 D: 152,414	18.02%	Not Achieved
4. Percent of members 21 years of age or older who received at least two preventive dental services six months apart during the measurement year.	N: 5,282 D: 62,777	8.41%	N: 5,745 D: 62,737	9.16%	N: 3,897 D: 72,041	5.41%	Not Achieved

N–Numerator; D–Denominator

For the baseline measurement period (calendar year 2018), **MCNA** reported that 54.63 percent of members 1 to 20 years of age and 21.01 percent of members 21 years of age or older received at least one preventive dental service during the measurement year. **MCNA**'s reported baseline percentages for members who received at least two preventive dental services six months apart during the measurement year were 27.12 percent for members 1 to 20 years of age and 8.41 percent for members 21 years of age and older.

For the first remeasurement period (calendar year 2019), **MCNA** reported a statistically significant increase over baseline results for performance indicators 1, 3, and 4. For Indicator 1, the DBM reported an increase of 0.66 percentage point in the percentage of members 1 to 20 years of age who received at least one preventive service in the measurement year, from 54.63 percent to 55.29 percent ($p < 0.0001$). For Indicator 3, the DBM reported an increase of 1.33 percentage points in the percentage of members 1 to 20 years of age who received at least two preventive services at least six months apart, from 27.12 percent to 28.45 percent ($p < 0.0001$). For Indicator 4, the DBM reported an increase of 0.75 percentage point in the percentage of members 21 years of age and older who received at least two preventive services at least six months apart, from 8.41 percent to 9.16 percent ($p < 0.0001$). The only decline in performance reported by **MCNA** for the first remeasurement was the decrease in the percentage of members 21 years of age and older who received at least one preventive service (Study Indicator 2), which fell 0.32 percentage point, from 21.01 percent to 20.69 percent.

For the second remeasurement period (calendar year 2020), **MCNA** reported declines in performance for performance indicators 1, 3, and 4; the DBM noted that the COVID-19 pandemic had impacted dental utilization rates during this measurement period. For Indicator 1, the DBM reported that 48.13 percent of members 1 to 20 years of age received at least one preventive dental service in the measurement year, a decrease of 6.5 percentage points from baseline and a decrease of 7.16 percentage

points from the first remeasurement. For Indicator 3, the DBM reported that 18.02 percent of members 1 to 20 years of age received at least two preventive services at least six months apart, a decrease of 9.1 percentage points from baseline and a decrease of 10.43 percentage points from the first remeasurement. For Indicator 4, the DBM reported that 5.41 percent of members 21 years of age and older received at least two preventive services at least six months apart, a decrease of 3.00 percentage points from baseline and a decrease of 3.75 percentage points from the first remeasurement. **MCNA** did report an improvement in performance at the second remeasurement for Study Indicator 2, the percentage of members 21 years of age and older who received at least one preventive service, which increased to 21.10 percent, an improvement of 0.09 percentage point over baseline and an improvement of 0.41 percentage point over the first remeasurement results. The improvement from baseline to the second remeasurement demonstrated by Performance Indicator 2 was not statistically significant ($p = 0.6391$).

Interventions

For the *Preventive Dental Visit* PIP, **MCNA** used brainstorming, provider feedback, and member feedback to identify barriers to improving performance indicator outcomes. To address the identified barriers, **MCNA** implemented the following interventions:

- Text message reminders, sent in the member's primary language, targeted toward members who have not received a dental service in the previous six months or who are due to schedule their second visit in the next six months.
- Member service representatives conduct targeted telephone outreach to members identified as being due for preventive dental services through automated care gap alerts. The telephone outreach includes assistance in identifying a dental provider who speaks the member's preferred language and three-way calling to schedule an appointment during the outreach call.
- Mailed and text reminders to parents of members turning 1 year of age to schedule a 1-year-old check-up for their child.
- Increased provider payment for fluoride services.
- DentalLink training program offered to select high-volume primary care providers to promote referral of high-risk members for preventive dental services

Strengths

The PIP validation findings suggest that **MCNA** completed a thorough application of the PIP Design stage (steps 1 through 6). A sound design created the foundation for **MCNA** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

In the Implementation stage (steps 7 and 8), **MCNA** progressed to reporting performance indicator results from the second (final) remeasurement period and carried out interventions to address identified barriers to improvement. The DBM accurately reported performance indicator data for each measurement period and statistical testing results comparing remeasurement performance to baseline performance. **MCNA** conducted appropriate QI processes to identify barriers, and it deployed

interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunity for improvement in the Outcomes stage of the PIP. In the Outcomes stage, **MCNA** reported results for the second annual remeasurement, or final measurement, during this validation cycle for four performance indicators. Three of the four performance indicators demonstrated statistically significant improvement over baseline performance at the first remeasurement; however, these three indicators did not demonstrate sustained improvement over baseline at the second remeasurement. The remaining performance indicator did not demonstrate statistically significant improvement at either the first or second remeasurement. **[Quality, Timeliness, and Access]**

To address the identified opportunity for improvement, HSAG recommended the following for **MCNA**:

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

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

During CY 2020–2021 there were no quality improvement recommendations identified for the Performance Improvement Projects activity.

Validation of Performance Measures

Results for Information Systems Standards Review

HSAG evaluated **MCNA**'s data systems for processing of each data type used for reporting the DHHS performance measure data. General findings are indicated below.

Results for Eligibility/Enrollment Data System Review

HSAG identified no concerns with **MCNA**'s process for receiving and processing eligibility data.

MCNA received enrollment files daily and monthly in the standard 834-file format from the Division of Medicaid and Long-Term Care's (MLTC's) secure file transfer protocol (sFTP) site. **MCNA** used DentalTrac, a proprietary dental system, to process and store member enrollment data. Eligibility files were updated in near real-time as soon as they became available from MLTC. Once a new file was identified, the file was downloaded from the sFTP site and uploaded into DentalTrac. **MCNA**'s eligibility team was then notified of the file receipt, including the number of records processed and the number of enrollment records terminated, added, or changed. The updated eligibility information was also made available to providers in real-time as well as through **MCNA**'s provider portal to ensure providers had the most current eligibility information possible before conducting member services.

Each file was subject to a validation process to ensure that only accurate data were loaded into DentalTrac. **MCNA**'s Electronic Data Interchange (EDI) team supervised the processing of eligibility files and reviewed all system logs associated with eligibility processing to ensure compliance. A series of validation reports were generated prior to processing for **MCNA**'s EDI team to review. If an issue was identified, the eligibility team manually reviewed the record in DentalTrac and compared it to the enrollment file. The eligibility team then worked with MLTC directly through email to correct the record if necessary. Adequate validation processes were in place to ensure data accuracy.

MCNA assigned a unique system-generated identification (ID) number when eligibility data were loaded into DentalTrac, which was matched on a variety of fields and maintained over time. **MCNA** used DentalTrac to ensure that no two members had the same subscriber ID and performed several verification processes to remove any duplicate subscriber IDs (e.g., one member with two unique ID numbers). System edits related to enrollment processing try to identify duplicate members based on name, date of birth, address, and social security number (SSN). As potential duplicate IDs were identified, a load report was generated and reviewed by the Eligibility and Enrollment Department. The eligibility team then manually reviewed the records, verified the information with MLTC, and merged the member's information into one member record to ensure that each unique member was counted once only in performance measure calculations.

During the virtual review, **MCNA** demonstrated the DentalTrac system, from which the auditor confirmed the accurate collection of eligibility effective dates, termination dates, and historical eligibility spans. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Results for Medical Service Data System (Claims/Encounters) Review

HSAG identified no issues with **MCNA**'s process for receiving and processing claims and encounter data.

MCNA had standard processes in place for credentialing and registering providers. **MCNA** required each new provider to complete an application and provide a resume, references, and license information to **MCNA** staff members for review and vetting. During the virtual review, the provider data processing steps described by **MCNA** appeared to be adequate.

Also, during the virtual review, **MCNA** demonstrated the DentalTrac system, from which the auditor confirmed the accurate receipt, documentation, and reconciliation of claims data. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Results for Data Integration Process Review

HSAG identified no concerns with **MCNA**'s data integration and measure calculation processes for performance measure reporting.

MCNA used the business intelligence PDI reporting tool to generate the performance measure rates based on the enrollment and claims stored and maintained in DentalTrac. **MCNA** utilized the PostgreSQL database to house all scripts, tables, and queries related to the rate production. **MCNA** used the PDI business intelligence tool to store all query output. The business intelligence tool allowed the **MCNA** end-users from its business intelligence team to perform ongoing review and oversight of the data. The **MCNA** business intelligence team reviewed numerator and denominator trends with each weekly refresh of the data. This enabled **MCNA** to monitor for accuracy as well as to identify any opportunities to act in a timely manner to impact the performance measure rates.

MCNA rates were reviewed by the IT report analysts as well as **MCNA**'s Business Department, Compliance Department, and the Chief Information Officer (CIO) prior to final rates being reported.

During the virtual review, the member-level data used by **MCNA** to calculate the performance measure rates were readily available for the auditor's review. **MCNA** was able to report valid and reportable rates. HSAG determined that **MCNA**'s data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Results for Performance Measures

Table D-3—MY 2019 and 2020 Performance Measure Results for MCNA

Performance Measure	MY 2019 Rate*	MY 2020 Results		
		Denominator	Numerator	Rate
Pdent: Preventive Dental Services—*The percentage of members 1–20 years of age who received at least one preventive dental service by or under the supervision of a dentist during the measurement year.*	55.67%	178,868	87,793	49.08%
ADV: Annual Dental Visit—*The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.*	54.13%	17,290	7,518	43.48%

Performance Measure	MY 2019 Rate*	MY 2020 Results		
		Denominator	Numerator	Rate
ADV: Annual Dental Visit—*The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.*	73.50%	26,311	16,218	61.64%
ADV: Annual Dental Visit—*The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.*	77.18%	33,261	21,704	65.25%
ADV: Annual Dental Visit—*The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.*	70.53%	33,122	19,746	59.62%
ADV: Annual Dental Visit—*The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.*	61.32%	26,669	13,637	51.13%
ADV: Annual Dental Visit—*The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.*	44.13%	4,641	1,750	37.71%
ADV: Annual Dental Visit—*The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*	68.53%	141,294	80,573	57.03%
UTL-CH-A: Utilization of Services, Dental Services—*The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.*	59.40%	175,546	88,436	50.38%
TRT-CH-A: Treatment Services, Dental Service—*The percentage of enrolled children under age 21 who received at least one treatment service within the reporting year.*	20.87%	175,546	28,723	16.36%
OEV-CH-A: Oral Evaluation, Dental Services—*The percentage of enrolled children under age 21 who received at least one comprehensive oral evaluation within the reporting year.*	55.86%	175,546	82,361	46.92%
CCN-CH-A: Care Continuity, Dental Services—*The percentage of children under age 21 enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.*	46.30%	143,225	58,408	40.77%

* MY 2019 rates were provided by DHHS and were not validated by HSAG.

Strengths

MCNA demonstrated sound practices related to both the claims review process and data integration and reporting process. **MCNA** indicated 20 percent of claims were reviewed by a claims examiner or the claims team prior to a claim being processed in order to verify accuracy and completeness prior to adjudication. In addition, 5 percent of claims were audited monthly by the **MCNA** claims audit team to ensure overall accuracy of post-adjudicated claims.

As part of measure reporting, **MCNA** denoted multiple levels of review performed by **MCNA**, which included reviews conducted by the IT Department, Business Department, and Compliance Department. By establishing multiple levels of review within various departments, **MCNA** is able to provide accurate rates, allowing multiple employees with different perspectives and knowledge to review the accuracy of the reported rates.

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG does not have any recommendations related to the accuracy of **MCNA**'s performance measure data, based on the 2021 PMV review.

It was noted by **MCNA** during the review that the MY 2020 rates declined due to the COVID-19 public health emergency, which caused provider practice closures for a period of time and reduced provider operating hours. Once provider practices reopened, **MCNA** noted that providers might have focused on patient triage in order to accommodate patients requiring urgent dental care, which placed general and preventive care as a secondary priority. In order to accommodate the potential backlog of patients during the continuation of the COVID-19 public health emergency, HSAG recommended **MCNA** to continue to work with its provider network to identify optimal office hours to ensure members can receive preventive services, and also for **MCNA** to continue to monitor its rates over time to identify pandemic-rate impact, ensuring lower access to preventive care is not driven by a non-pandemic cause.

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

During CY 2020–2021 there were no quality improvement recommendations identified for the Performance Measure activity.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table D-4—Summary of Scores for Each Standard for MCNA

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
I. Enrollment and Disenrollment	7	6	6	0	1	100%
II. Member Rights and Confidentiality	6	5	5	0	1	100%
III. Member Information	22	20	17	3	2	85%
IV. Emergency and Poststabilization Services	12	9	9	0	3	100%
V. Adequate Capacity and Availability of Services	14	12	12	0	2	100%
VI. Coordination and Continuity of Care	9	6	6	0	3	100%
VII. Coverage and Authorization of Services	19	17	14	3	2	82%
VIII. Provider Selection and Program Integrity	16	16	16	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	2	2	0	50%
X. Practice Guidelines	3	3	3	0	0	100%
XI. Health Information Systems	6	6	6	0	0	100%
XII. Quality Assessment and Performance Improvement	6	6	6	0	0	100%
XIII. Grievance and Appeal System	26	26	22	4	0	85%
Totals*	**150**	**136**	**124**	**12**	**14**	**91%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Table D-5 presents the number of elements for each record type; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for CY 2021–2022.

Table D-5—Summary of MCNA Scores for the CY 2021–2022 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Grievances	50	32	30	2	18	94%
Appeals	70	60	60	0	10	100%
Denials	60	50	41	9	10	82%
Totals*	**180**	**142**	**131**	**11**	**38**	**92%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Strengths

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

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

MCNA achieved full compliance for the appeals record reviews. **[Quality, Timeliness, and Access]**

MCNA achieved full compliance for the Enrollment and Disenrollment standard, demonstrating the MCE had policies and procedures that included all required provisions. Members are accepted into the health plan without restriction. Appropriate processes were in place related to member and MCE requests for disenrollment. **[Quality and Access]**

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

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

MCNA achieved full compliance for the Adequate Capacity and Availability of Services standard, demonstrating **MCNA** maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services for its membership. **[Timeliness and Access]**

MCNA achieved full compliance in the Coordination and Continuity of Care standard, demonstrating the MCE had processes in place for their care management program. **[Quality, Timeliness, and Access]**

MCNA achieved full compliance in the Provider Selection and Program Integrity standard, demonstrating **MCNA** had appropriate provider monitoring and processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. **MCNA** had developed a compliance committee to ensure information sharing at the staff, management, and leadership levels. **[Quality, Timeliness, and Access]**

MCNA achieved full compliance in the Practice Guidelines standard, demonstrating the MCE had a process in place to review and update clinical practice guidelines regularly. **[Quality]**

MCNA achieved full compliance in the Health Information Systems standard, demonstrating the MCE had processes in place for how information is captured, processes, and stored in the MCE's data warehouse. **[Quality and Access]**

MCNA achieved full compliance in the Quality Assessment and Performance Improvement standard, demonstrating the MCE had maintained a well-developed, thorough, and continuous QAPI program. **MCNA**'s program outlined activities such as performance improvement projects, performance measures, mechanisms to detect both underutilization and overutilization of services, and means of assessing the quality and appropriateness of care for members with special health care needs. **[Quality]**

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

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

MCNA received a score of 85 percent in the Member Information standard. **MCNA** must update the member handbook to include conspicuously visible taglines in Spanish. HSAG recommended that **MCNA** use the same content used in its English tagline. In addition, **MCNA** must update its member handbook to include the following information: the availability of assistance to request a State fair hearing; the fact that, when requested by the member: benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing and if benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member. Moreover, HSAG recommended that **MCNA** work to reduce the number of contrast errors on its website to ensure that members with visual challenges and color blindness can view information on the website with ease. Importantly, during the interview, **MCNA** staff members described efforts that were underway to expand on the accessibility indicator to provide members with a more detailed view of a specific provider's accommodations. HSAG recommended that **MCNA** continue with these efforts as it will add clarity for members who may require certain types of accommodations. **[Access]**

MCNA received a score of 82 percent in the Coverage and Authorization of Services standard. **MCNA** must develop a mechanism to send members an NABD at the time of any decision to deny payment for a service, in whole or in part. Additionally, **MCNA** must revise policies and procedures and develop a mechanism to ensure that if **MCNA** proposes to terminate, suspend, or reduce previously authorized services prior to the end of the authorization period, it provides a 10-day advance notice of such termination or change to the service. Also, **MCNA** must develop a mechanism to ensure that NABDs are written at a 6.9 grade reading level (to the extent possible) as required by **MCNA**'s contract with DHHS. While **MCNA** had processes to consult with the requesting provider when needed, the peer-to-peer and reconsideration processes described in policy and by staff members during the interview occurred following the member having received a NABD. HSAG recommended that when providers are notified of an overturn of the decision as a result of the reconsideration or peer-to-peer review, that members receive a copy of the notification, or an equivalent notification, as well. Since a resolution letter is not required for the informal processes and members do not receive the message of approval after they have received the NABD, they may be reluctant to schedule the care. **[Timeliness and Access]**

MCNA received a score of 50 percent in the Subcontractual Relationships and Delegation standard. **MCNA** must update all written delegation agreements to include the required language from 42 CFR §438.230(c)(2). Additionally, the Fiserv agreement did not include the language required by 42 CFR §438.230(c)(3). **MCNA** must update all written delegation agreements to include the following language: the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State; the subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members; the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; if the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. **[Quality]**

MCNA received a score of 85 percent in the Grievance and Appeal System standard. **MCNA** must ensure that communication sent to the member provides a resolution in clear terms that are easily understood. Also, **MCNA** must clarify its policies to ensure members are afforded the right to request a State fair hearing at any time after receiving the notice of appeal resolution, up to 120 days following the date of the appeal resolution letter. Furthermore, **MCNA** must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal; however, following the appeal, if the member requests continuation during the State fair hearing, he or she must request both the State fair hearing and continued service within 10 calendar days following the notice of appeal resolution. Importantly, **MCNA** must ensure that the provider manual includes accurate information about the member grievance an appeal system and clarify that: members may file an appeal orally or in writing, and oral requests to appeal do not require written follow-up regardless of whether they are standard or expedited requests; the definition of "adverse

benefit determination" includes the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other); members who wish to continue services during the appeal must request the continuation within 10 days following the NABD, or before the intended effective date of the termination or change (whichever is later); however, the member has the full 60-day filing time frame to file the appeal. **[Quality, Timeliness, and Access]**

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

For the standards reviewed in CY 2020–2021, the following opportunities for improvement were identified and resulted in required actions:

- Partner with University of Alabama at Birmingham to address the prior findings related to inconsistent CAHPS methodology.
- Ensure child and adult CAHPS findings are reported separately to MLTC.
- Ensure that CAHPS results are stratified by county.
- Ensure a statistically random sample is drawn, based on members who have had a dental visit with an **MCNA** provider, in order to be consistent with CAHPS methodology.
- Have a procedure in place that outlines how they will evaluate survey results to ensure appropriate statistical analysis is employed in order to target improvement efforts. In an effort to compare performance of **MCNA** in Nebraska, the DBM might consider against other states in which they operate with a similar benefit structure.
- Include questions in their provider satisfaction survey that assess perceptions of the enrollment process and complaint resolution process. The DBM explained that the state handles provider enrollment; however, perceptions of this process should still be taken into consideration at the state's request. Further, only one complaint received during the review period indicates that there may be a discrepancy in what qualifies as a provider complaint and what is formally recorded as such. The DBM should include a question in the Provider Survey to assess the complaint process, with "N/A" as a choice for those providers that did not file a complaint (formally or informally) with the DBM during the year.

MCNA reported engaging in the following required corrective actions:

- Contracted with certified NCQA vendor, DataStat, to administer the child and adult CAHPS survey.
- Implemented a change in methodology for the 2021 provider satisfaction survey and it will be available to providers via the Provider Portal by the end of Q3 2021. Additional survey questions were also included to assess provider perception of the enrollment process and complaint resolution process.

HSAG determined that by conducting the above activities, **MCNA** adequately addressed the CY 2020–2021 recommendations.

Validation of Network Adequacy

Results

MCNA's provider data evaluation findings are presented in Table D-6. One hundred percent of all records contained values for 19 of 24 requested data fields. However, four data fields were never populated: panel capacity (Panel_Capacity), the indicator identifying whether the provider speaks a non-English language (Alt_LangSpoken), a text description of the provider's primary language spoken (Prim_Lang), and a text description of additional languages spoken (Addl_Lang). Gray shading indicates that the percentage of values with a valid format or valid value was not assessed for the field.

Table D-6—Assessment of MCNA's Provider Data Completeness and Validity

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
BusName**	The provider's business name, if applicable	100.0		
FName***	The first name of an individual provider	100.0		
LName***	The last name of an individual provider	100.0		
ProvID	A unique identification number assigned for a servicing or billing provider	100.0		
NPI	National Provider Identifier, a HIPAA standard unique identifier assigned to each health care provider	100.0	100.0	100.0
Sex***	The provider's gender	100.0	100.0	100.0
Address1	The first street address line for each provider/business servicing address	100.0		
City	The city of each provider/business servicing address	100.0		
State	The state abbreviation code for each provider/business servicing address	100.0	100.0	100.0
ZIP	The five-digit ZIP or postal code for each provider/business servicing address	100.0	100.0	100.0
County	The five-digit FIPS code representing the state and county in which the servicing address is located	100.0	100.0	100.0
Phone	The telephone number associated with the servicing address at which the provider serves Heritage Health members	100.0	100.0	100.0

Data Field Name	Data Field Description	Percent of Records Present[1]	Percent of Records with Valid Format[2]	Percent of Records with Valid Values[3]
New_Pt	Indicator identifying whether the provider accepts new patients	100.0	100.0	100.0
Panel_Capacity	The maximum number of Heritage Health members that the provider will accept	0.0	0.0	
PCP_Flag	Indicator identifying if the provider is a primary care provider (PCP)	100.0	100.0	100.0
Alt_LangSpoken***	Indicator identifying whether the provider speaks a non-English language, including American Sign Language (ASL)	0.0	0.0	0.0
Prim_Lang***	Text description of the provider's primary language spoken, including English	0.0	0.0	
Addl_Lang***	Text description of the provider's additional language spoken	0.0	0.0	
Spec_cd1	Primary specialty of the provider/business	100.0		
Provtype1	Text description of provider's primary provider type	100.0		
Txnmy_cd1	Primary provider taxonomy code of the provider/business—10-digit code	100.0	100.0	100.0
Degree***	Degree or certification attained, if available (e.g., Medical Doctor (MD), Registered Nurse (RN), Licensed Professional Counselor (LPC))	100.0		
Start_Date	The provider's MCE contract start date	100.0	100.0	100.0
End_Date****	The provider's MCE contract end date	1.8	1.8	1.8

[1] *Percent of Records Present* indicates that the MCE submitted a non-missing data value for the specified data field.

[2] *Percent of Records with Valid Format* indicates that the MCE's present data values aligned with the data format in the data request document.

[3] *Percent of Records with Valid Values* indicates the MCE's present data values aligned with the allowable data values specified in the data request document.

Percentages are based on the total submitted records unless specified below:

** Only facilities included in calculation

*** Only individual practitioners included in calculation

**** Contract end dates for ongoing contracts were not evaluated.

Strengths

These results indicate that **MCNA** collected most of the required critical data elements and provided near complete data for most of the data elements. **[Quality and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

HSAG identified opportunities for **MCNA** to improve its data collection and submission processes to address potential issues in the future. DHHS has forwarded these recommendations to the plan for follow-up:

- **MCNA** supplied HSAG with the network data used for the NAV analysis. Therefore, **MCNA** should review its data practices to address deficiencies identified by HSAG. **[Quality]**
- **MCNA** should conduct an in-depth internal investigation into HSAG's key data quality findings to identify the nature of the data issues that led to the findings and formulate a strategy for correcting these deficiencies:
  - 10.6 percent of **MCNA**'s providers were associated with more than 10 physical service location addresses. This may be indicative of errors in data that could impact provider directories and time and distance analyses. **[Quality and Access]**
  - **MCNA** indicated that it does not maintain data regarding maximum provider panel size. MCEs should maintain complete and accurate data regarding maximum provider panel size to monitor provider availability to provide adequate and timely care to members. **[Quality and Access]**
  - 0.0 percent of provider records included any language data. Data regarding languages spoken by providers are important for identifying potential language barriers to care for non-English-speaking members for dental providers as well as medical providers. **[Quality and Access]**

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

During CY 2020–2021, there were no quality improvement recommendations identified for the NAV activity. NAV activities for CY 2021–2022 will take into account the strengths and weaknesses identified in this preliminary analysis.

Appendix E. Information System Standards

Overview of the HEDIS Compliance Audit

Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. Organizations seeking NCQA accreditation or wishing to publicly report their HEDIS performance results undergo an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization. The audits are conducted in compliance with NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures*. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the organizations are reliable, valid, accurate, and can be compared to one another.

During the HEDIS audit, data management processes were reviewed using findings from the NCQA HEDIS Roadmap review, interviews with key staff members, and a review of queries and output files. Data extractions from systems used to house production files and generate reports were reviewed, including a review of data included in the samples for the selected measures. Based on validation findings, the LOs produced an initial written report identifying any perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement. The LOs also produced a final report with updated text and findings based on comments concerning the initial report.

The FAR included information on the organization's IS capabilities; each measure's reportable results; MRR validation results; the results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and opportunities and recommendations for improvement of data completeness, data integrity, and health outcomes.

Information Systems Standards

Listed below are the Information Systems Standards published in NCQA's *HEDIS MY 2020 Volume 5 HEDIS Compliance Audit: Standards, Policies, and Procedures*.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

IS 1.1 Industry standard codes (e.g., International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM], International Classification of Diseases, Tenth Revision, Procedure Coding System [ICD-10-PCS], Current Procedural Terminology [CPT], Healthcare Common Procedure Coding System [HCPCS]) are used and all characters are captured.

IS 1.2 Principal codes are identified and secondary codes are captured.

IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

IS 1.4 Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.

IS 1.5 Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for measure reporting.

IS 1.6 The organization continually assesses data completeness and takes steps to improve performance.

IS 1.7 The organization regularly monitors vendor performance against expected performance standards.

Rationale

The organization must capture all clinical information pertinent to the delivery of services to provide a basis for calculating measures. The audit process ensures that the organization consistently captures sufficient clinical information. Principal among these practices and critical for computing clinical measures is consistent use of standardized codes to describe medical events, including nationally recognized schemes to capture diagnosis, procedure, diagnosis related group (DRG), and Diagnostic and Statistical Manual of Mental Disorders (DSM) codes. Standardized coding improves the comparability of measures through common definition of identical clinical events. The organization must cross-reference nonstandard coding schemes at the specific diagnosis and service level to attain equivalent meaning. The integrity of measures requires using standard forms, controlling receipt processes, editing and verifying data entry, and implementing other control procedures that promote completeness and accuracy in receiving and recording medical information. The transfer of information from medical charts to the organization's databases should be subject to the same standards for accuracy and completeness.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

IS 2.1 The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.

IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

IS 2.3 The organization continually assesses data completeness and takes steps to improve performance.

IS 2.4 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Controlling receipt processes, editing and verifying data entry, and implementing other control procedures to promote completeness and accuracy in receiving and recording member information are critical in databases that calculate measures. Specific member information includes age, gender,

benefits, product line (commercial, Medicaid, and Medicare), and the dates that define periods of membership so gaps in enrollment can be determined.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

IS 3.1 Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting.

IS 3.2 The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.

IS 3.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

IS 3.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 3.5 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Controlling receipt processes, editing and verifying data entry, and implementing other control procedures to promote completeness and accuracy in receiving and recording provider information are critical in databases that calculate measures. Specific provider information includes the provider's specialty, contracts, credentials, populations served, date of inclusion in the network, date of credentialing, board certification status, and information needed to develop medical record abstraction tools.

IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight

IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).

IS 4.2 Retrieval and abstraction of data from medical records are reliably and accurately performed.

IS 4.3 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.

IS 4.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 4.5 The organization regularly monitors vendor performance against expected performance standards.

Rationale

MRR validation ensures that record abstraction performed by or on behalf of the entity meets standards for sound processes and that abstracted data are accurate. Validation includes not only an over-read of

abstracted medical records but also a review of MRR tools, policies, and procedures related to data entry and transfer, and materials developed by or on behalf of the entity.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

IS 5.2 The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.

IS 5.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

IS 5.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 5.5 The organization regularly monitors vendor performance against expected performance standards.

IS 5.6 Data approved for ECDS reporting met reporting requirements.

IS 5.7 NCQA-certified eCQM data met reporting requirements.

Rationale

Organizations may use a supplemental database to collect and store data, which is then used to augment rates. These databases must be scrutinized closely since they can be standard, nonstandard, or member-reported. The auditor must determine whether sufficient control processes are in place related to data collection, validation of data entry into the database, and use of these data. Mapping documents and file layouts may be reviewed as well, to determine compliance with this standard. Beginning with HEDIS 2014, NCQA provided new validation requirements for auditing supplemental data to ensure that all data included for reporting are complete and have required supporting documentation.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

IS 6.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.

IS 6.2 Data transfers to HEDIS repository from transaction files are accurate.

IS 6.3 File consolidations, extracts, and derivations are accurate.

IS 6.4 Repository structure and formatting are suitable for measures and enable required programming efforts.

IS 6.5 Report production is managed effectively and operators perform appropriately.

IS 6.6 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Prior to data integration and reporting, it is essential that data transfer, consolidation, and control procedures support the integrity of the measure reporting. The organization's quality assurance practices

and backup procedures serve as an organizational infrastructure supporting all information systems. The practices and procedures promote accurate and timely information processing and data protection in the event of a disaster.

IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

IS 7.1 Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.

IS 7.2 Report production is managed effectively and operators perform appropriately.

IS 7.3 Measure reporting software is managed properly with regard to development, methodology, documentation, version control, and testing.

IS 7.4 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Calculating rates requires data from multiple sources. The systems used to assemble the data and to make the required calculations should be carefully constructed and tested. Data needed to calculate measures are produced by the organization's information systems and may be directly or indirectly affected by IS practices and procedures.