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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2022–2023 External Quality Review Technical Report

for

Heritage Health Program

April 2023

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Table of Contents

1. Executive Summary ... 1-1
Background ... 1-1
Introduction ... 1-1
Heritage Health Program ... 1-1
Scope of External Quality Review ... 1-2
Reader's Guide ... 1-3
Report Purpose and Overview ... 1-3
How This Report Is Organized ... 1-3
Definitions ... 1-4
2. Statewide Comparative Results ... 2-1
Validation of Performance Improvement Projects ... 2-1
Results ... 2-1
Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects ... 2-1
Validation of Performance Measures ... 2-2
Results for Information Systems Standards Review ... 2-2
Results for Performance Measures ... 2-5
Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Performance Measure Rates and Validation ... 2-14
Assessment of Compliance With Medicaid Managed Care Regulations ... 2-19
Results ... 2-19
Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Compliance With Regulations ... 2-20
Validation of Network Adequacy ... 2-21
Results ... 2-22
Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Network Adequacy ... 2-27
Overall Statewide Conclusions, Opportunities for Improvement, and Recommendations ... 2-29
Nebraska's Managed Care Quality Strategy ... 2-30
Goals and Objectives ... 2-30
Best and Emerging Practices ... 2-31
Recommendations ... 2-31
3. Methodology ... 3-1
Validation of Performance Improvement Projects ... 3-1
Objectives ... 3-1
Technical Methods of Data Collection ... 3-1
Description of Data Obtained ... 3-2
How Data Were Aggregated and Analyzed ... 3-2
How Conclusions Were Drawn ... 3-2
Validation of Performance Measures ... 3-3
Objectives ... 3-3

Technical Methods of Data Collection 3-4
Description of Data Obtained 3-6
How Data Were Aggregated and Analyzed 3-7
How Conclusions Were Drawn 3-7
Information Systems Standards Review 3-7
Performance Measure Results 3-8
Assessment of Compliance With Medicaid Managed Care Regulations 3-11
Objectives 3-13
Technical Methods of Data Collection 3-13
Description of Data Obtained 3-15
How Data Were Aggregated and Analyzed 3-15
How Conclusions Were Drawn 3-16
Validation of Network Adequacy 3-17
Objectives 3-17
Technical Methods of Data Collection 3-17
Description of Data Obtained 3-18
How Data Were Aggregated and Analyzed 3-19
How Conclusions Were Drawn 3-21
Aggregating and Analyzing Statewide Data 3-22
Appendix A. Healthy Blue A-1
Validation of Performance Improvement Projects A-1
Results A-1
Strengths A-3
Summary Assessment of Opportunities for Improvement and Recommendations A-3
Follow-Up on Prior Year’s Recommendations (Requirement §438.364[a][6]) A-3
Validation of Performance Measures A-6
Results for Information Systems Standards Review A-6
Results for Performance Measures A-10
Strengths A-18
Summary Assessment of Opportunities for Improvement and Recommendations A-22
Follow-Up on Prior Year’s Recommendations [Requirement §438.364(a)(6)] A-27
Assessment of Compliance With Medicaid Managed Care Regulations A-32
Results A-32
Strengths A-33
Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations A-33
Follow-Up on Prior Year’s Recommendations [Requirement §438.364(a)(6)] A-34
Validation of Network Adequacy A-39
Results A-39
Strengths A-44
Summary Assessment of Opportunities for Improvement and Recommendations A-45
Follow-Up on Prior Year’s Recommendations [Requirement §438.364(a)(6)] A-45
Appendix B. Nebraska Total Care B-1
Validation of Performance Improvement Projects B-1

Results B-1
Strengths B-2
Summary Assessment of Opportunities for Improvement and Recommendations B-3
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] B-3
Validation of Performance Measures B-5
Results for Information Systems Standards Review B-5
Results for Performance Measures B-9
Strengths B-17
Summary Assessment of Opportunities for Improvement and Recommendations B-21
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] B-24
Assessment of Compliance With Medicaid Managed Care Regulations B-32
Results B-32
Strengths B-33
Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations B-34
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] B-35
Validation of Network Adequacy B-40
Results B-40
Strengths B-45
Summary Assessment of Opportunities for Improvement and Recommendations B-45
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] B-46
Appendix C. United Healthcare Community Plan C-1
Validation of Performance Improvement Projects C-1
Results C-1
Strengths C-2
Summary Assessment of Opportunities for Improvement and Recommendations C-3
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] C-3
Validation of Performance Measures C-5
Results for Information Systems Standards Review C-5
Results for Performance Measures C-8
Strengths C-17
Summary Assessment of Opportunities for Improvement and Recommendations C-21
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] C-24
Assessment of Compliance With Medicaid Managed Care Regulations C-28
Results C-28
Strengths C-29
Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations C-30
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] C-31
Validation of Network Adequacy C-37
Results C-37
Strengths C-43
Summary Assessment of Opportunities for Improvement and Recommendations C-43
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] C-43

Appendix D. Managed Care of North America, Inc. D-1
Validation of Performance Improvement Projects D-1
Results D-1
Strengths D-2
Summary Assessment of Opportunities for Improvement and Recommendations D-3
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] D-3
Validation of Performance Measures D-4
Results for Information Systems Standards Review D-4
Results for Eligibility/Enrollment Data System Review D-4
Results for Medical Service Data System (Claims/Encounters) Review D-5
Results for Data Integration Process Review D-6
Results for Performance Measures D-7
Strengths D-9
Summary Assessment of Opportunities for Improvement and Recommendations D-10
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] D-10
Assessment of Compliance With Medicaid Managed Care Regulations D-12
Results D-12
Strengths D-13
Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations D-13
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] D-14
Validation of Network Adequacy D-17
Results D-17
Strengths D-20
Summary Assessment of Opportunities for Improvement and Recommendations D-20
Follow-Up on Prior Year's Recommendations [Requirement §438.364(a)(6)] D-21
Appendix E. Information System Standards E-1
Overview of the HEDIS Compliance Audit E-1
Information Systems Standards E-1
IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry E-1
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry E-2
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry E-3
IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight E-3
IS 5.0—Supplemental Data—Capture, Transfer, and Entry E-4
IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity E-4
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity E-5

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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, timeliness, 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. During contract year (CY) 2022–2023, DHHS is using the exemption option allowed under 42 CFR §438.362 to exempt **United Healthcare Community Plan**'s (**UHCCP**'s) Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) and **Nebraska Total Care**'s (**NTC**'s) Dual Eligible Special Needs Plan (D-SNP) from EQR.

[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: July 27, 2022.

[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: July 27, 2022.

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 CY 2022–2023, 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 conducted the following optional activity:

- **Validation of network adequacy (Protocol 4).** Network Adequacy Validation (NAV) activities in CY 2022–2023 were designed to build on the previous year's activities, conducting the first full evaluation of the MCEs' compliance with Heritage Health contract standards for geographic access to care.

[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: July 27, 2022.

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 2022–2023. 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 accessibility 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 2022–2023.

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

Section 2—Comparative Statewide Results provides statewide comparative results organized by EQR activity, and statewide trends and commonalities used to assess the quality, timeliness, and 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, timeliness, and access to health care provided by the MCEs.

Section 3—Methodology contains the following information for each 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, timeliness, 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 2022–2023 EQR-related activities, as well as follow-up on recommendations made based on the prior year's EQR-related activities. Additionally, a more in-depth explanation of the NCQA IS standards is provided in *Appendix 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.

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 [primary care case management] 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]

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.

[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.

[1-5] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCEs*.

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]

[1-6] 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 the CY 2022–2023 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	*Plan All-Cause Readmissions*	*Met*
NTC	*Plan All-Cause Readmissions*	*Met*
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	*Met*
MCNA	*First Dental Visit at Age 1*	*Met*

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

For MCEs statewide, the following conclusions were identified:

- The MCEs followed methodologically sound designs for the PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCEs reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- The MCEs conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**

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

- Two of the four MCEs reported indicator results that demonstrated a decline in performance from baseline to Remeasurement 1. **[Quality]**
- Only one of the four MCEs reported indicator results that demonstrated statistically significant improvement from baseline to Remeasurement 1. **[Quality]**

For MCEs statewide, the following recommendations were identified:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality]**
- 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]**
- Use Plan-Do-Study-Act (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]**

Validation of Performance Measures

Results for Information Systems Standards Review

In addition to ensuring that data were uniformly captured, reported, and presented, HSAG evaluated each MCO's 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 2021 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 2021 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. • Contracted vendors are regularly monitored against expected performance standards.	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.
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.	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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
• 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.	
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. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	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.
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 validated data resulting from the Data Aggregator Validation (DAV) program 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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
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.
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) 2021

Performance Measures	HBN	NTC	UHCCP
CMS Adult Core Set Measures#			
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 18 to 64**	17.58%	21.31%	24.63%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 65+**	22.22%	16.25%	21.97%
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	32.85%	37.93%	43.22%

Performance Measures	HBN	NTC	UHCCP
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—18 to 64**	3.09%	3.53%	4.99%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—65+**	3.45%	1.41%	6.28%
*PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,000 Member Months)**	1.43	2.82	0.97
CMS Child Core Set Measures #			
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^*	74.65	77.47	68.42
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^*	32.61	35.97	30.76
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—10 to 19^*	24.56	29.93	24.82
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Total^*	31.51	52.21	30.11
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 1 Year	21.02%	24.22%	26.42%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 2 Years	30.45%	31.23%	33.70%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 3 Years	26.61%	29.72%	32.09%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	26.13%	28.26%	30.50%

The MCO's CMS Adult and Child Core measures were not required to be audited and are presented for information only.
^ Rate is reported per 1,000 beneficiary months rather than a percentage.
* For this indicator, a lower rate indicates better performance.

Table 2-4—Nebraska MCO Performance and Statewide Weighted Averages—HEDIS MY 2021

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
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	73.72% ★★★	69.34% ★★	71.53% ★★	71.61%
Counseling for Nutrition—Total	64.72% ★★★	55.96% ★★	66.42% ★★★	62.56%
Counseling for Physical Activity—Total	61.31% ★★★	57.18% ★★	65.94% ★★★	61.59%

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
CIS: Childhood Immunization Status				
Combination 3	72.99% ★★★★★	70.07% ★★★★★	72.51% ★★★★★	71.96%
Combination 7	64.72% ★★★★★	61.56% ★★★★★	63.99% ★★★★★	63.54%
Combination 10	54.26% ★★★★★	47.45% ★★★★★	49.39% ★★★★★	50.73%
IMA: Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	77.13% ★★★	78.10% ★★★	77.37% ★★★	77.50%
Combination 2 (Meningococcal, Tdap, HPV)	31.14% ★★★	33.33% ★★★	34.55% ★★★	32.96%
LSC: Lead Screening in Children				
Lead Screening in Children	70.80% ★★★★	68.94% ★★★★	70.32% ★★★★	70.09%
BCS: Breast Cancer Screening				
Breast Cancer Screening	42.69% ★★	54.48% ★★★★	64.83% ★★★★★	58.15%
CCS: Cervical Cancer Screening				
Cervical Cancer Screening	58.88% ★★★★	58.39% ★★★★	57.42% ★★★	58.20%
CHL: Chlamydia Screening in Women				
Ages 16 to 20 Years	26.60% ★	28.02% ★	28.35% ★	27.67%
Ages 21 to 24 Years	37.70% ★	44.46% ★	39.71% ★	40.57%
Total	30.90% ★	34.22% ★	32.69% ★	32.60%
Effectiveness of Care: Respiratory Conditions				
CWP: Appropriate Testing for Pharyngitis				
Ages 3 to 17	74.12% ★★★	70.31% ★★	71.20% ★★★	71.87%
Ages 18 to 64	65.29% ★★★★	63.08% ★★★★	60.64% ★★★	62.86%
Ages 65 and Older	NA	NA	NA	NA
Total	71.81% ★★★★	68.15% ★★★	68.10% ★★★	69.30%
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.00% ★★★★	22.41% ★★★	28.83% ★★★★★	27.10%

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
PCE: Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	56.29% ★★	72.20% ★★★★	73.35% ★★★★	69.15%
Bronchodilator	71.86% ★★	87.89% ★★★★	86.53% ★★★★	83.63%
AMR: Asthma Medication Ratio				
Ages 5 to 11	75.36% ★★★	83.71% ★★★★★	78.21% ★★★★	79.20%
Ages 12 to 18	62.07% ★★	72.69% ★★★★	71.43% ★★★★	69.51%
Ages 19 to 50	60.92% ★★★★	62.29% ★★★★	70.88% ★★★★★	65.40%
Ages 51 to 64	61.36% ★★★★	59.26% ★★★★	64.79% ★★★★★	62.55%
Total	66.04% ★★★★	71.99% ★★★★★	72.59% ★★★★★	70.68%
Effectiveness of Care: Cardiovascular Conditions				
CBP: Controlling High Blood Pressure				
Controlling High Blood Pressure	53.04% ★★	61.31% ★★★★	71.53% ★★★★★	64.09%
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	65.91% ★	76.67% ★★★	80.70% ★★★	74.81%
Effectiveness of Care: Diabetes				
CDC: Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	88.81% ★★★★★	89.78% ★★★★★	91.00% ★★★★★	90.05%
*HbA1c Poor Control (>9.0%)**	40.88% ★★★	39.90% ★★★★	31.14% ★★★★★	36.28%
HbA1c Control (<8.0%)	48.66% ★★★	51.82% ★★★★	60.10% ★★★★★	54.63%
Eye Exam (Retinal) Performed	50.61% ★★★	57.66% ★★★★★	65.94% ★★★★★	59.40%
Blood Pressure Control (<140/90 mm Hg)	66.18% ★★★★	66.91% ★★★★	76.89% ★★★★★	71.14%
Effectiveness of Care: Behavioral Health				
AMM: Antidepressant Medication Management				
Effective Acute Phase Treatment	61.69% ★★★★	64.57% ★★★★	66.16% ★★★★★	64.30%
Effective Continuation Phase Treatment	47.66% ★★★★	47.12% ★★★★	52.98% ★★★★★	49.45%

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
ADD: Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	38.99% ★★★	40.68% ★★★★	39.15% ★★★	39.58%
Continuation and Maintenance Phase	46.78% ★★★	48.39% ★★★	47.85% ★★★	47.61%
FUH: Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Ages 6 to 17	44.95% ★★★	46.12% ★★★	57.83% ★★★★★	49.75%
30-Day Follow-Up—Ages 6 to 17	70.41% ★★★	68.98% ★★★	80.58% ★★★★★	73.38%
7-Day Follow-Up—Ages 18 to 64	34.25% ★★★★	29.22% ★★★	41.14% ★★★★	35.13%
30-Day Follow-Up—Ages 18 to 64	53.59% ★★★★	47.10% ★★★	61.84% ★★★★	54.49%
7-Day Follow-Up—Ages 65 and Older	NA	NA	NA	NA
30-Day Follow-Up—Ages 65 and Older	NA	NA	NA	NA
7-Day Follow-Up—Total	37.60% ★★★	34.49% ★★★	45.98% ★★★★	39.61%
30-Day Follow-Up—Total	58.86% ★★★	53.92% ★★★	67.21% ★★★★★	60.24%
FUM: Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	40.91% ★★★★	43.33% ★★★★	43.78% ★★★★	42.78%
30-Day Follow-Up—Total	59.25% ★★★★	61.39% ★★★★	64.21% ★★★★★	61.79%
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder				
7-Day Follow-Up—Total	23.24% ★★★	25.08% ★★★	21.78% ★★★	23.43%
30-Day Follow-Up—Total	43.37% ★★★	42.52% ★★★	42.33% ★★★	42.74%
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence				
7-Day Follow-Up—Total	13.96% ★★★★	16.20% ★★★★	19.04% ★★★★★	16.49%
30-Day Follow-Up—Total	23.42% ★★★★	22.12% ★★★★	24.11% ★★★★	23.26%
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.78% ★★★	80.96% ★★★★	82.81% ★★★★★	80.75%

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	48.86% ★	65.48% ★★★	75.21% ★★★★★	68.70%
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	75.68% ★★★★	75.47%
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	52.89% ★★	64.82% ★★★★	73.98% ★★★★★	67.52%
Effectiveness of Care: Overuse/Appropriateness				
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.20% ★★★★★	0.64% ★★★	0.43% ★★★★	0.42%
URI: Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	90.20% ★★	89.58% ★★	90.33% ★★	90.04%
Ages 18 to 64 Years	80.47% ★★★	79.40% ★★★	80.56% ★★★	80.12%
Ages 65 Years and Older	NA	NA	NA	70.45%
Total	88.75% ★★★	87.75% ★★	88.53% ★★★	88.35%
LBP: Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	76.89% ★★★★	73.55% ★★★	76.31% ★★★★	75.62%
HDO: Use of Opioids at High Dosage				
*Use of Opioids at High Dosage**	2.06% ★★★★	2.39% ★★★★	5.19% ★★★	3.63%
Access/Availability of Care				
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Ages 13 to 17	33.62% ★★	33.05% ★★	30.89% ★★	32.50%
Engagement of AOD Treatment—Total—Ages 13 to 17	12.50% ★★★★	15.48% ★★★★	12.20% ★★★	13.39%
Initiation of AOD Treatment—Total—Ages 18 and Older	41.82% ★★★	44.50% ★★★★	39.05% ★★	41.76%
Engagement of AOD Treatment—Total—Ages 18 and Older	12.27% ★★★	13.17% ★★★	11.07% ★★★	12.16%
Initiation of AOD—Total—Total	41.12% ★★★	43.62% ★★★	38.42% ★★	41.02%

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
Engagement of AOD—Total—Total	12.29% ★★★	13.35% ★★★	11.16% ★★★	12.25%
PPC: Prenatal and Postpartum Care				
Timeliness of Prenatal Care	76.16% ★★	77.86% ★★	87.59% ★★★★	80.65%
Postpartum Care	68.37% ★★	76.16% ★★★	85.89% ★★★★★	76.91%
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	60.83% ★★★★	65.23% ★★★★★	63.03% ★★★★★	62.88%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	66.85% ★★★★	67.85% ★★★★	68.60% ★★★★	67.67%
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	0.05 NC	0.02 NC	0.02
*Bariatric Weight Loss Surgery—45–64 Years—Male^*	0.02 NC	0.02 NC	0.00 NC	0.01
*Bariatric Weight Loss Surgery—0–19 Years—Female^*	0.00 NC	0.00 NC	0.01 NC	0.00
*Bariatric Weight Loss Surgery—20–44 Years—Female^*	0.16 NC	0.20 NC	0.19 NC	0.18
*Bariatric Weight Loss Surgery—45–64 Years—Female^*	0.39 NC	0.18 NC	0.20 NC	0.24
*Tonsillectomy—0–9 Years—Total^*	0.58 NC	0.56 NC	0.54 NC	0.56
*Tonsillectomy—10–19 Years—Total^*	0.31 NC	0.35 NC	0.33 NC	0.33
*Hysterectomy, Abdominal—15–44 Years—Female^*	0.05 NC	0.09 NC	0.06 NC	0.07
*Hysterectomy, Abdominal—45–64 Years—Female^*	0.18 NC	0.22 NC	0.20 NC	0.20
*Hysterectomy, Vaginal—15–44 Years—Female^*	0.11 NC	0.20 NC	0.13 NC	0.15
*Hysterectomy, Vaginal—45–64 Years—Female^*	0.09 NC	0.10 NC	0.09 NC	0.09

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
*Cholecystectomy, Open—30–64 Years—Male^*	0.01 NC	0.02 NC	0.03 NC	0.02
*Cholecystectomy, Open—15–44 Years—Female^*	0.01 NC	0.01 NC	0.00 NC	0.01
*Cholecystectomy, Open—45–64 Years—Female^*	0.07 NC	0.00 NC	0.00 NC	0.02
*Cholecystectomy, Laparoscopic—30–64 Years—Male^*	0.30 NC	0.44 NC	0.52 NC	0.43
*Cholecystectomy, Laparoscopic—15–44 Years—Female^*	0.77 NC	0.80 NC	0.67 NC	0.74
*Cholecystectomy, Laparoscopic—45–64 Years—Female^*	0.73 NC	0.76 NC	0.85 NC	0.79
*Back Surgery—20–44 Years—Male^*	0.36 NC	0.34 NC	0.31 NC	0.33
*Back Surgery—45–64 Years—Male^*	0.81 NC	0.76 NC	0.82 NC	0.80
*Back Surgery—20–44 Years—Female^*	0.16 NC	0.19 NC	0.22 NC	0.19
*Back Surgery—45–64 Years—Female^*	0.77 NC	0.90 NC	0.96 NC	0.89
*Mastectomy—15–44 Years—Female^*	0.03 NC	0.02 NC	0.02 NC	0.03
*Mastectomy—45–64 Years—Female^*	0.26 NC	0.20 NC	0.18 NC	0.21
*Lumpectomy—15–44 Years—Female^*	0.10 NC	0.08 NC	0.10 NC	0.09
*Lumpectomy—45–64 Years—Female^*	0.26 NC	0.43 NC	0.37 NC	0.36
AMB: Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total^,**	44.38 ★★★★	52.21 ★★	45.79 ★★★	47.31
*Outpatient Visits—Total^*	324.28 NC	360.81 NC	355.80 NC	346.84
IPU: Inpatient Utilization—General Hospital/Acute Care—Total				
*Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^*	5.75 NC	6.84 NC	5.89 NC	6.14
Average Length of Stay—Total Inpatient—Total All Ages	7.32 NC	5.08 NC	5.55 NC	5.94
*Discharges per 1,000 Member Months—Maternity—Total All Ages^*	3.78 NC	3.97 NC	3.08 NC	3.59

Performance Measures	HBN	NTC	UHCCP	MY 2021 NE MMC Weighted Average
Average Length of Stay—Maternity—Total All Ages	2.45 NC	2.66 NC	2.38 NC	2.50
*Discharges per 1,000 Member Months—Surgery—Total All Ages^*	1.03 NC	1.49 NC	1.37 NC	1.29
Average Length of Stay—Surgery—Total All Ages	9.15 NC	9.59 NC	9.82 NC	9.56
*Discharges per 1,000 Member Months—Medicine—Total All Ages^*	2.40 NC	2.83 NC	2.53 NC	2.58
Average Length of Stay—Medicine—Total All Ages	11.25 NC	4.87 NC	5.72 NC	7.15
Risk Adjusted Utilization				
PCR: Plan All-Cause Readmissions				
*Observed Readmissions—Total**	11.33% NC	13.08% NC	11.41% NC	12.03%
*Expected Readmissions—Total**	10.40% NC	10.90% NC	11.40% NC	10.88%
*O/E Ratio—Total**	1.09 ★★	1.20 ★	1.00 ★★★	1.11
Measures Collected Using Electronic Clinical Data Systems				
BCS-E: Breast Cancer Screening				
Breast Cancer Screening	—	—	64.63% NC	64.63%

— 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 2021 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 2021 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—MY 2021

Performance Measures	MCNA MY 2021 Rates
Annual Dental Visit	
ADV: Annual Dental Visit members 2–3 years of age	45.73%
ADV: Annual Dental Visit members 4–6 years of age	66.13%

Performance Measures	MCNA MY 2021 Rates
ADV: Annual Dental Visit members 7–10 years of age	69.12%
ADV: Annual Dental Visit members 11–14 years of age	61.40%
ADV: Annual Dental Visit members 15–18 years of age	51.61%
ADV: Annual Dental Visit members 19–20 years of age	34.16%
ADV: Annual Dental Visit members 2–20 years of age	58.40%
Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	
TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	35.50%
Utilization of Services, Dental Services	
UTL-CH-A: Utilization of Services; Dental Services	52.73%
Treatment Services, Dental Services	
TRT-CH-A: Treatment Services; Dental Services	18.36%
Oral Evaluation, Dental Services	
OEV-CH-A: Oral Evaluation; Dental Services	49.39%
Care Continuity, Dental Services	
CCN-CH-A: Care Continuity; Dental Services	37.03%

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 3*, *Combination 7*, and *Combination 10*, and *Lead Screening in Children* measure indicators were a strength for all three MCOs. All three MCOs for the *Childhood Immunization Status* measure indicators ranked at or above NCQA's Quality Compass®,[2-1] national Medicaid Health Maintenance Organization (HMO) HEDIS MY 2021 75th percentile benchmark, while all three MCOs ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark for the *Lead Screening in Children* measure. The *Childhood Immunization Status—Combination 3*, *Combination 7*, 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

[2-1] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

when they are vulnerable.[2-2,2-3] In addition, the *Lead Screening in Children* rates demonstrate children under 2 years of age are adequately receiving a lead blood testing to ensure they are maintaining limited exposure to lead. **[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. For these measure indicators, all three MCOs' rates ranked below NCQA's Quality Compass national Medicaid HMO MY 2021 10th percentile benchmark. Untreated 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 continued to recommend that DHHS determine if the MCOs are following up annually with sexually active members through any type of communications such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuation of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), 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 19 to 50*, *Ages 51 to 64*, and *Total* measure indicators were a strength for all three MCOs. All three MCOs' rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark for these measure indicators. 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]**

Effectiveness of Care: Cardiovascular Conditions Domain

When conducting the PMV, HSAG did not identify any common strengths or opportunities for improvement across the three MCOs within the Effectiveness of Care: Cardiovascular Conditions domain.

[2-2] 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 1, 2022.

[2-3] Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief.

[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: Nov 1, 2022.

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care—HbA1c Testing* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for all three MCOs. For these measure indicators, all three MCOs' rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. According to NCQA (as cited by the Centers for Disease Control and Prevention [CDC]), proper diabetes 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.[2-6] **[Quality]**

Effectiveness of Care: Behavioral Health Domain

The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were a strength for all three MCOs. For these measure indicators, all three MCOs' rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. Based on these rates, MCO 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). **[Quality]**

In addition, the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, along with the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators were also a strength for all three MCOs. For these measure indicators, all three MCOs' rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. This indicates the MCOs were appropriately managing care for patients 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. Furthermore, the MCOs appear to be managing the care of members 13 years of age and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within seven days or 30 days. **[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 all three MCOs. All three MCOs' rates for this measure indicator ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. This indicates that a diagnosis of URI resulted in an antibiotic dispensing event for more members in

[2-6] Centers for Disease Control and Prevention (CDC). 2020. "National diabetes statistics report, 2020." Atlanta, GA: U.S. Department of Health and Human Services. Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html. Accessed on: Nov 1, 2022.

comparison to the national benchmark. Often, antibiotics are prescribed inappropriately and can lead to adverse clinical outcomes and antibiotic resistance. HSAG continued to recommend that DHHS conduct a root cause analysis to ensure the MCOs are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[2-7] In addition, HSAG also continued to recommend 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—Initiation of AOD Treatment—Total—Ages 13 to 17* measure indicator was a weakness for all three MCOs. All three MCOs' rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark for this measure indicator. This indicates that adolescents 13 to 17 years of age did not initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis. Treatment has been associated with improved alcohol outcomes, better employment outcomes and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care.[2-8] HSAG recommended that DHHS conduct a root cause analysis with the MCOs to ensure their providers are reaching members with an identified substance use disorder (SUD) to initiate in follow-up treatment. The MCOs 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]**

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* and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators were also a strength for all three MCOs. All three MCOs' rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark for these measure indicators. This indicates children within the first 30 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]**

[2-7] 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: Nov 1, 2022.

[2-8] National Library of Medicine. Patient Characteristics Associates with Treatment Initiation and Engagement Among Individuals Diagnosed with Alcohol and Other Drug Use in the Emergency Department and Primary Care Settings. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6669120/. Accessed on: Nov 1, 2022.

Risk Adjusted Utilization Domain

When conducting the PMV, HSAG did not identify any common strengths or opportunities for improvement across the three MCOs within the Risk Adjusted Utilization domain.

Measures Reported Using Electronic Clinical Data System (ECDS) Domain

When conducting the PMV, HSAG did not identify any common strengths or opportunities for improvement across the three MCOs within the Measures Reported Using ECDS domain.

DBM Conclusions, Opportunities for Improvement, and Recommendations

MCNA denoted spending a substantial amount of time supporting its provider network. **MCNA** received approximately 3,000 emails a month addressing questions submitted by its providers. **MCNA** provided monthly newsletters, provider bulletins, email blasts, and reference materials to its network providers to help keep them up to date on any industry trends. In addition, **MCNA** hosted a quarterly seminar for providers to address any individual questions live and for providers to generate any feedback to **MCNA** directly. **MCNA**'s Provider Relations Department also reached out to providers individually and presented updates on how the providers were performing on specific measure metrics in comparison to similar providers in their area. **[Quality]**

Additionally, **MCNA**'s provider portal served as an all-inclusive resource site for providers to submit claims and access provider manuals and bulletins, listed a directory of **MCNA** contacts to help address any concerns, housed additional forms for submission, and offered links to **MCNA**'s YouTube channel that hosts instructional tutorials for provider references. **[Quality]**

HSAG did not identify any opportunities for improvement related to the accuracy of **MCNA**'s performance measure data during the 2022 performance measure validation (PMV) review, other than the recommendations mentioned below. **[Quality, Timeliness, and Access]**

MCNA noted during the review that it is continuing to exercise HSAG's recommendation from last year as **MCNA** works with its provider network to identify optimal office hours to ensure members can receive preventive services. Additionally, **MCNA** is continuing to monitor its rates over time to identify pandemic rate impact, ensuring lower access to preventive care is not being driven by a non-pandemic issue. **MCNA** indicated that it is in constant contact with providers to ensure member access is a priority. A backlog of patients still exists for many providers as a result of the PHE, but **MCNA** stated the backlog is slowly being reduced based on member availability and member priorities to attend appointments. **MCNA** is anticipating the backlog will be alleviated by August 2023. **[Quality, Timeliness, and Access]**

For MY 2021, **MCNA**'s rates for the NCQA *Annual Dental Visit—19–20 Years of Age* and for the DQA *Care Continuity, Dental Services* measures decreased. **MCNA** contributed the *Annual Dental Visit—19–20 Years of Age* rate decrease to a volatile age group. **MCNA** noted that members in this age group typically lack parental supervision and are less likely to follow up on services conducted during their adolescence. **MCNA** also discussed that the *Care Continuity, Dental Services* measure rate decrease was

due to office closures and members seeing a different practice based on service availability. Members under the *Care Continuity, Dental Services* measure would not have been counted toward the numerator for the measure if members did not follow up with the same practice for consecutive services. HSAG recommended that **MCNA** work with providers to illustrate the importance of scheduling members immediately after they receive dental services to ensure an appointment has been set before they leave the office. After members leave the office, it becomes difficult to schedule them through follow-up communications. With a backlog of scheduled patients, providers should try to schedule college-aged members during time frames most convenient for that age group, taking personal schedules into consideration (e.g., school, work) to optimize their availability. **MCNA** should also remind providers to use dental provider software or office staff to send out automatic reminders via email or text message if a member has missed a follow-up visit or is past due for service. **[Quality, Timeliness, and Access]**

Assessment of Compliance With Medicaid Managed Care Regulations

In CY 2021–2022, HSAG collaborated with DHHS to design a three-year review cycle. In CY 2022–2023, HSAG reviewed seven of the 13 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 statewide average compliance monitoring results and the year that each standard was reviewed.

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

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**Statewide Average Results**	
Standard I—Enrollment and Disenrollment	97%	100%
Standard II—Member Rights and Confidentiality	88%	
Standard III—Member Information	83%	
Standard IV—Emergency and Poststabilization Services	100%	100%
Standard V—Adequate Capacity and Availability of Services	97%	
Standard VI—Coordination and Continuity of Care	100%	
Standard VII—Coverage and Authorization of Services	86%	

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**Statewide Average Results**	
Standard VIII—Provider Selection and Program Integrity	97%	96%
Standard IX—Subcontractual Relationships and Delegation	81%	88%
Standard X—Practice Guidelines	100%	100%
Standard XI—Health Information Systems	100%	100%
Standard XII—Quality Assessment and Performance Improvement	100%	100%
Standard XIII—Grievance and Appeal System	78%	

* Bold text indicates standards that HSAG reviewed during CY 2022–2023.
**Grey shading indicates standards for which no comparison results are available.

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

Table 2-7—Record Review Statewide Performance for MCEs

Record Type	HBN	NTC	UHCCP	MCNA	Statewide Total Score*
Credentialing	100%	100%	100%	99%	99.72%
Recredentialing	99%	100%	99%	100%	99.36%
Totals*	**99%**	**100%**	**99%**	**99%**	**99.55%**

* The total score was calculated by dividing the total number of met elements by the total number of applicable elements. See Table A-11, Table B-11, Table C-11, and Table D-10 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 seven standards reviewed during CY 2022–2023. **[Quality, Timeliness, and Access]**
- All four MCEs received 100 percent compliance with the Enrollment and Disenrollment standard, demonstrating that the MCEs had policies and procedures that included all required provisions. **[Quality 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. **[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]**

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

- Three out of four MCEs are required to develop CAPs based on the CY 2022–2023 compliance review. **[Quality, Timeliness, and Access]**
- Three out of the four MCEs received 94 percent compliance with the Provider Selection and Program Integrity standard, indicating that providers may not be appropriately credentialed or assessed in accordance with contractual requirements. **[Quality, Timeliness, and Access]**
- Two out of the four MCEs received 75 percent compliance with the Subcontractual Relationships and Delegation standard, indicating gaps in the MCEs' processes for ensuring that their contracts or written agreements with their delegates included all required federal and State contractual provisions. **[Quality]**

For MCEs statewide, the following recommendations were identified:

- Two out of the four MCEs must make revisions to subcontractor agreements to fully comply with all required federal and State contract provisions. The provisions should be included verbatim, when appropriate, to ensure no misinterpretation of the requirements. **[Quality, Timeliness, and Access]**
- Three out of four MCEs must develop CAPs to address noncompliance with the Provider Selection and Program Integrity standard. **[Quality, Timeliness, and Access]**
- Two out of the four MCEs must develop CAPs to address noncompliance with the Subcontractual Relationships and Delegation standard. **[Quality]**

Validation of Network Adequacy

This is the first year in which HSAG has conducted a full validation of network adequacy in Nebraska. In collaboration with DHHS, HSAG designed and conducted the following activities to assess the adequacy of the MCEs' compliance with program and contract standards for geographic access to care:

- **Network Capacity Analysis**: HSAG compared the number of providers in each MCE-contracted provider network to the number of members enrolled with the MCE. This provider-to-member ratio (provider ratio) represents a summary statistic used for informational purposes to infer the overall capacity of a provider network to deliver services to Medicaid members.

- **Geographic Network Distribution Analysis**: HSAG evaluated the geographic distribution of the MCEs' contracted providers relative to their member populations. The MCEs are contractually obligated to maintain a robust provider network accessible to 100 percent of Heritage Health members (unless otherwise specified), within geographic access standards established by DHHS. For most provider categories, the standard is stated in terms of miles from the member's residence; for hospitals, the standard is stated in terms of minutes of travel time. For each MCE, HSAG calculated the percentage of members with access to the MCE-contracted provider network to evaluate the extent to which each MCE met the geographic access standards. In addition, HSAG calculated the average travel time (minutes) and distance (miles) from each member to the nearest two providers for each MCE and provider category for informational purposes only.

Results

Network Capacity Analysis

Table 2-8 displays the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for each MCE. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for obstetrics and gynecology (OB/GYN) were limited to female members 15 years of age and older.

Table 2-8—Statewide Population of Eligible Members for MCEs

Member Population	HBN	NTC	UHCCP	MCNA
Children 18 Years and Younger	64,892	63,862	65,748	194,502
Females 15 Years and Older	37,596	44,616	43,113	NA
All Members*	115,170	125,042	125,386	365,598

*"All Members" may not equal the sum of "Children 18 Years and Younger" and "Females 15 Years and Older" as the latter categories overlap and do not include adult males. In addition, "All Members" includes members whose age was not known.
NA—Not applicable.

Table 2-9 and Table 2-10 display the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for the MCOs and **MCNA**, respectively.

Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. Less variation is expected within provider categories assuming that the MCEs have member populations with similar needs. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table 2-9—Statewide Network Capacity Analysis Results for MCOs*

Provider Category**	HBN		NTC		UHCCP	
	Providers	Ratio***	Providers	Ratio***	Providers	Ratio***
PCPs	5,017	1:23	3,012	1:42	1,894	1:67
High Volume Specialists:******						
- Cardiologists	278	1:415	336	1:373	109	1:1,151
- Neurologists	241	1:478	252	1:497	58	1:2,162
- OB/GYNs	396	1:95	337	1:133	197	1:219
- Oncologists/Hematologists	121	1:952	123	1:1,017	53	1:2,366
- Orthopedics	337	1:342	345	1:363	133	1:943
- Pharmacies	114	1:1,011	241	1:519	417	1:301
Behavioral Health Inpatient and Residential Service Providers	4	1:28,793	5	1:25,009	5	1:25,078
Behavioral Health Outpatient Assessment and Treatment Providers	3,078	1:38	3,065	1:41	791	1:159
Hospitals	163	1:707	108	1:1,158	100	1:1,254

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** Providers include those serving all ages as well as those serving age-specific segments of the population. Member-to-provider ratios could be much higher for child members to pediatric providers, for example, than for adult members to providers that primarily serve adults.

*** In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older.

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

Table 2-10—Statewide Network Capacity Analysis Results for MCNA*

Provider Category	MCNA	
	Providers	Ratio**
General Dentists	600	1:610
Oral Surgeons	14	1:26,115
Orthodontists	27	1:13,541
Periodontists	16	1:22,850
Pediadontists	56	1:3,474

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** In calculating the ratios, all covered members were considered except in the case of Pediadontists (pediatric dentists), where the member population was limited to members 18 years of age and younger.

Geographic Network Distribution Analysis

Nebraska has set geographic access standards for most providers in terms of distance in miles, apart from Hospitals for which the standard is defined in terms of time in minutes.

Table 2-11 displays the percentage of each MCO's members with access to their provider network according to the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results were reported statewide.

Table 2-11—Percentage of Members With Required Access to Care by Provider Category, Urbanicity, and MCO*

Provider Category	Urbanicity**	HBN	NTC	UHCCP
		Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
PCPs	Urban	>99.9%	100.0%	>99.9%
	Rural	100.0%	100.0%	100.0%
	Frontier	100.0%	100.0%	100.0%
High Volume Specialists* **				
− Cardiologists	Statewide	>99.9%	>99.9%	99.1%
− Neurologists	Statewide	>99.9%	100.0%	94.9%
− OB/GYNs	Statewide	>99.9%	100.0%	99.8%
− Oncologists/Hematologists	Statewide	99.5%	99.5%	99.4%
− Orthopedics	Statewide	100.0%	100.0%	99.5%
Pharmacies	Urban (90%)	89.8%	95.0%	96.3%
	Rural (70%)	48.4%	62.7%	90.7%
	Frontier (70%)	80.9%	97.4%	98.2%
Behavioral Health Inpatient and Residential Service Providers	Urban	98.0%	100.0%	97.3%
	Rural	97.0%	100.0%	97.4%
	Frontier	87.6%	100.0%	90.2%

Provider Category	Urbanicity**	HBN	NTC	UHCCP
		Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	100.0%	>99.9%	99.9%
	Rural	100.0%	99.9%	97.6%
	Frontier	99.5%	97.6%	97.9%
Hospitals	Statewide	99.3%	97.1%	98.7%

* Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific urbanicity.

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

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

The State of Nebraska is divided into six Behavioral Health Regions, each comprising several counties which collaborate in planning service implementation for behavioral health in their area. For that reason, access to behavioral health services were also examined by region, using the same distance standards. Table 2-12 displays the percentage of each MCO's members with the access to care required by contract standards for behavioral health categories for the MCOs by region.

Table 2-12—Percentage of Members With Required Access to Behavioral Health Services by Provider Category, Region, and MCO*

Region	HBN	NTC	UHCCP
	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers			
Region 1	100.0%	100.0%	100.0%
Region 2	57.8%	100.0%	49.7%
Region 3	100.0%	100.0%	99.4%
Region 4	>99.9%	100.0%	99.8%
Region 5	100.0%	100.0%	100.0%
Region 6	100.0%	100.0%	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers			
Region 1	100.0%	100.0%	100.0%
Region 2	99.8%	98.2%	98.4%

Region	HBN	NTC	UHCCP
	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Region 3	100.0%	100.0%	100.0%
Region 4	100.0%	99.8%	94.9%
Region 5	100.0%	100.0%	100.0%
Region 6	100.0%	100.0%	100.0%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.

Table 2-13 displays the percentage of members with the access to care required by geographic access standards for all applicable provider categories and urbanicities for **MCNA**.

Table 2-13—Percentage of Members With Required Access to Dental Care by Provider Category and Urbanicity*

Provider Category	Urbanicity	MCNA
		Percentage of Members Within Standard
General Dentists	Urban	100.0%
	Rural	>99.9%
	Frontier	100.0%
Oral Surgeons	Urban	87.0%
	Rural	62.6%
	Frontier	21.0%
Orthodontists	Urban	93.5%
	Rural	73.2%
	Frontier	84.8%
Periodontists	Urban	74.8%
	Rural	36.9%
	Frontier	0.0%
Pediadontists	Urban	99.5%
	Rural	82.7%
	Frontier	86.4%

*Red cells indicate that minimum geographic access standards were not met by **MCNA** for a specific provider category in a specific urbanicity.

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

Overall, the Nebraska CY 2022–2023 NAV results suggest that the MCEs have comprehensive provider networks. Nebraska's MCEs have generally contracted with a variety of providers to ensure that members have access to a broad range of health care services within geographic time/distance standards. There are some opportunities for improvement, particularly in certain geographic areas and for certain provider categories (i.e., pharmacies and dental specialists).

For MCEs statewide, the following conclusions were identified:

Network Capacity Analysis

- Provider ratios range from a low of one PCP per 23 members (**HBN**), to a high of one Behavioral Health Inpatient and Residential Service Provider per 28,793 members (**HBN**). **[Quality, Timeliness, and Access]**
- Among non-institutional physical and behavioral health providers (i.e., excluding Hospitals, Behavioral Health Inpatient and Residential Service Providers, Pharmacies, and Dental providers), **UHCCP** has the largest number of members per provider in all categories, sometimes by a large margin. **[Quality, Timeliness, and Access]**
- Among dental providers, the ratio for General Dentists (one per 610 members) exceeds the ratio for all other dental provider categories, including pediatric dentists (Pediadontists; one per 3,474 enrolled children 18 years of age and younger). After General Dentists and Pediadontists, all other dental provider categories have provider ratios higher than one provider per 10,000 members. **[Quality, Timeliness, and Access]**

Geographic Network Distribution Analysis

- Of the 18 provider category/urbanicity combinations across all MCOs, **HBN** met the relevant standard for six geographic combinations, **NTC** met standards for 11 combinations, and **UHCCP** met standards for five combinations. **[Timeliness and Access]**
- Of those combinations, 15 (all but Pharmacies) set the standard at 100 percent compliance. Two of these provider category/urbanicity combination standards were met by all MCEs—PCPs in rural and frontier counties. Standards were not met by at least one MCE in the remaining 13 categories. However, the percentage of members with access in compliance with the geographic access standards across all MCEs, provider categories, and urbanicities was generally above 95 percent and frequently above 99 percent. **[Timeliness and Access]**
- Across the 15 provider categories with a 100 percent geographic access standard, there was only one MCO with a provider network accessible to less than 90 percent of members─87.6 percent of **HBN**

members had the required access to Behavioral Health Inpatient and Residential Service Providers in frontier counties.[2-9] **[Timeliness and Access]**

- No MCOs met access standards for Cardiologists or Oncologists/Hematologists in any urbanicity, and no MCOs met access standards for Behavioral Health Outpatient Assessment and Treatment Providers in frontier counties. **[Timeliness and Access]**
- No MCOs met the access standard for Hospitals, which requires that 100 percent of members have access to at least one hospital within 30 minutes' drive time, with results ranging from 97.1 percent (**NTC**) to 99.3 percent (**HBN**). **[Timeliness and Access]**
- At the level of the Behavioral Health Region, all MCOs met standards for Behavioral Health Inpatient and Residential Service Providers and Behavioral Health Outpatient Assessment and Treatment Providers in regions 1, 5, and 6. In contrast, all MCOs faced challenges meeting standards for access to Behavioral Health Inpatient or Outpatient care in Regions 2 and 4. **[Timeliness and Access]**
- Of 12 provider category/Behavioral Health Region combinations, **HBN** met standards in nine, **NTC** met standards in ten, and **UHCCP** met standards in seven. **[Timeliness and Access]**
- Among dental providers, **MCNA**'s network met geographic access standards only for General Dentists in urban and frontier counties. Standards were not met in any urbanicity for Pediadontists or for any dental specialty provider category. **[Timeliness and Access]**

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

<u>Network Capacity Analysis</u>

- **HBN** has the highest ratio of members to providers for Pharmacies, with one pharmacy per 1,011 members, compared to one per 519 members for **NTC** and one per 301 members for **UHCCP**. **[Quality, Timeliness, and Access]**
- **UHCCP** has the highest ratio for Hospitals (1:1,254), but is closely followed by **NTC** (1:1,158), whereas the ratio is considerably lower for **HBN** (1:707). **[Quality, Timeliness, and Access]**
- Among dental providers, the ratio of members to providers is lowest for General Dentists (one per 610 members) of all dental provider categories, including pediatric dentists (Pediadontists; one per 3,474 enrolled children 18 years of age and younger). After General Dentists and Pediadontists, all other dental provider categories have provider ratios higher than one provider per 10,000 members. **[Quality, Timeliness, and Access]**

[2-9] The geographic access standard requires sufficient provider service locations so that members in rural and frontier counties can travel to a provider and return home within a single day. At DHHS' direction, HSAG translated this standard for purposes of the NAV analyses to mean 100 percent of members should have access to at least one provider within 240 miles.

Geographic Network Distribution Analysis

- For Pharmacies, with geographic access standards less than 100 percent, **HBN** members were not found to have sufficient network access in urban and rural counties, and **NTC** members lacked the required access in rural counties. **[Timeliness and Access]**
- The greatest deficits in access to behavioral health services were found in Behavioral Health Region 2, where members enrolled in two of the three MCOs lacked the required member access for Behavioral Health Inpatient and Residential Service Providers (**HBN**, with 57.8 percent of members with access, and **UHCCP** with 49.7 percent of members with access). **[Timeliness and Access]**
- For **MCNA**, the three biggest deficits in access were for Periodontists in rural counties (36.9 percent) and frontier counties (0.0 percent of members with access), and Oral Surgeons in frontier counties (21.0 percent). For all other specialties, at least 60 percent of members had access to care within the geographic access standards. **[Timeliness and Access]**

For MCEs statewide, the following recommendations were identified:

- For the provider categories for which each MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Quality, Timeliness, and Access]**

Overall Statewide Conclusions, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from CY 2022–2023 to comprehensively assess the MCEs' performance in providing quality, timely, and accessible health care services to Nebraska's Medicaid and CHIP members. For each MCE reviewed, HSAG provides a 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 2022–2023 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.

Throughout each of the EQR activities, all the 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.

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 the 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

CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their enrollees and update it every three years.

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. The Quadruple Aim governs the quality strategy and is the framework through which MLTC is advancing managed care to a higher quality standard. The goals of the Quadruple Aim are to improve the member experience of care, the provider experience, and the health of populations, and reduce the per-capita cost of health care. The Quadruple Aim represents a rigorous and innovative approach to fulfilling the mission of Medicaid to furnish medical assistance to disadvantaged and vulnerable individuals through improving population health, enhancing the beneficiary and provider experience, and ensuring the long-term financial viability of the Medicaid program.

Goals and Objectives

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
- Delivery system reform initiatives that MLTC has both implemented and planned.

Best and Emerging Practices

Best practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve a service, health outcome, systems process, or operational procedure. MLTC identified the following best and emerging practices:

- Working to better incorporate health equity into all activities of health care delivery
- Integrating dental with physical and behavioral health
- Implementing a centralized credentialing vendor for all MCEs' provider enrollment
- Begin increasing the scope and duration of the clinical care/case management conferences to allow additional population health initiatives, quality metrics, PIPs, and discussion

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:

- Continue to 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 MCE as they become compliant with requirements. MLTC staff members should continue routine operational calls and/or meetings, be available and responsive to MCEs' routine and spontaneous communications, and have continual contact and meetings, as needed, to address questions.
- Establish a workgroup to address common improvement opportunities surrounding the EQR-related activities or areas of non-compliance.
- Throughout the annual EQR-related activities, continue striving to improve member experience of care, provider experience, the health of populations, and reduce the per-capita cost of health care services. Additionally, the MCEs and MLTC should continue to meet and discuss difficult-to-place patients, high-cost claimants, and medically/behaviorally complex patients, along with any projects and population-based initiatives.
- Collaborate with HSAG to require each MCE to complete any identified CAPs during the compliance monitoring review.
- Continue to address opportunities for improvement and implement any recommendations, which will facilitate the MCEs improvement in areas of quality, timeliness, and access to care for the Nebraska Medicaid members. MLTC should continue the monthly operational meetings with the MCEs as a means to discuss performance as it relates to quality, access, and timeliness of care.
- Continue to effectively manage the oversight and work collaboratively with each MCE to ensure program operations, quality and compliance measures, and reporting are meeting contractual and performance standards.
- Continue to monitor and assess MCE performance, along with routinely adjusting performance measures and other EQR-related goals. Additionally, MLTC should encourage and strive for a positive trend in performance for each MCE.
- Consider revising the quality strategy to reflect MLTC's goals and objectives. For each objective, MLTC should outline a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the quality strategy.
- Collaborate with the MCEs and discuss quality initiatives, best practices, and common barriers to improvement on measures.
- Continue to strive to improve member health outcomes by encouraging MCEs to meet and exceed quality strategy goals and holding MCEs accountable for performance.
- Encourage the MCEs to implement interventions targeting performance measures that did not meet the national Medicaid benchmarks.

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

[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: July 27, 2022.

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 submission form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP submission form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG 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 (NA)*, or *Not Assessed*. 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, timeliness, 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 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	*Plan All-Cause Readmissions*	✓		
NTC	*Plan All-Cause Readmissions*	✓		
UHCCP	*Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*	✓		
MCNA	*First Dental Visit at Age 1*	✓	✓	✓

Validation of Performance Measures

Objectives

The primary objectives of the 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.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - 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 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.

[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: July 27, 2022.

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

- Accuracy checks of the final HEDIS MY 2020 rates as presented within the NCQA-published Interactive Data Submission System (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 2021 (i.e., Jan 1, 2021–December 30, 2021) performance measures be validated during 2022 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 as part of the PMV activity:

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. **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 as part of the PMV activity:

1. **ISCAT:** This was received from the DBM. The completed ISCAT provided HSAG with background information on DHHS' 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 2021 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 2021 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

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

- 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 2021 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 2021, 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:

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

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 2021 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021.

To draw conclusions about the quality, timeliness, and access to care 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 *NA* are 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			
CDC: Comprehensive Diabetes Care	✓		
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	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
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	✓	✓	✓

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

Performance Measures	Quality	Timeliness	Access
Annual Dental Visit			
ADV: Annual Dental Visit members 2–3 years of age	✓	✓	✓
ADV: Annual Dental Visit members 4–6 years of age	✓	✓	✓
ADV: Annual Dental Visit members 7–10 years of age	✓	✓	✓
ADV: Annual Dental Visit members 11–14 years of age	✓	✓	✓
ADV: Annual Dental Visit members 15–18 years of age	✓	✓	✓
ADV: Annual Dental Visit members 19–20 years of age	✓	✓	✓
ADV: Annual Dental Visit members 2–20 years of age	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services			
TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	✓	✓	✓
Utilization of Services, Dental Services			
UTL-CH-A: Utilization of Services; Dental Services	✓	✓	✓
Treatment Services, Dental Services			
TRT-CH-A: Treatment Services; Dental Services	✓	✓	✓
Oral Evaluation, Dental Services			
OEV-CH-A: Oral Evaluation; Dental Services	✓	✓	✓
Care Continuity, Dental Services			
CCN-CH-A: Care Continuity; Dental Services	✓	✓	✓

Assessment of Compliance With Medicaid Managed Care Regulations

Table 3-4 delineates the compliance review activities as well as the standards that were reviewed during the current three-year compliance review cycle. CAPs from findings during the 2021 compliance reviews were evaluated and resolved in 2022.

Table 3-4—Summary of Compliance Standards and Associated Regulations

	Year One (2021–2022)	Year Two (2022–2023)	Year Three (2023–2024)
Standard	**Review of Standards**		
Standard I—Enrollment and Disenrollment	✓	✓	
Standard II—Member Rights and Confidentiality	✓		✓
Standard III—Member Information	✓		✓
Standard IV—Emergency and Poststabilization Services	✓	✓	
Standard V—Adequate Capacity and Availability of Services	✓		✓
Standard VI—Coordination and Continuity of Care	✓		✓
Standard VII—Coverage and Authorization of Services	✓		✓
Standard VIII—Provider Selection and Program Integrity	✓	✓	
Standard IX—Subcontractual Relationships and Delegation	✓	✓	

	Year One (2021–2022)	Year Two (2022–2023)	Year Three (2023–2024)
Standard	**Review of Standards**		
Standard X—Practice Guidelines	✓	✓	
Standard XI—Health Information Systems	✓	✓	
Standard XII—Quality Assessment and Performance Improvement	✓	✓	
Standard XIII—Grievance and Appeal System	✓		✓

HSAG divided the federal regulations into 13 standards consisting of related regulations and contract requirements. Table 3-5 describes the standards and associated regulations and requirements reviewed for each standard.

Table 3-5—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 PMV activity.	

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. The objective of each virtual 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, timeliness, and access to care 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 3-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 3-6—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: July 27, 2022.

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 credentialing and recredentialing files 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 2022–2023 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 (credentialing and recredentialing)
- 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 credentialing and recredentialing files 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 care 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, timeliness, and access to care 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, timeliness, or access to care and services provided by the MCEs. Table 3-7 depicts assignment of the standards to the domains of care.

Table 3-7—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

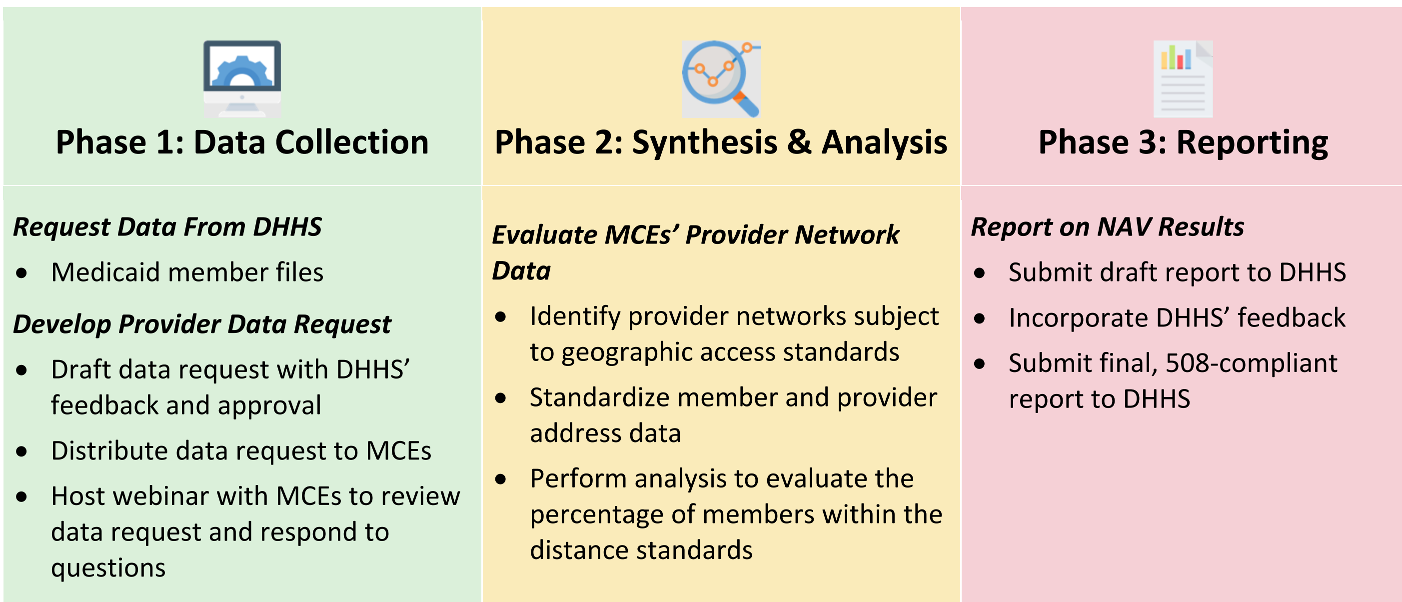
Compliance Review Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard VIII—Provider Selection and Program Integrity	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		

Validation of Network Adequacy

Objectives

HSAG developed the optional NAV activities for Heritage Health MCEs in anticipation of the release of the CMS protocol. CY 2022–2023 NAV activities were designed to help DHHS meet the NAV requirements once the EQR protocol is released. In CY 2022–2023, HSAG's NAV analysis continued to build on the work completed in CY 2021–2022 to assess the quality and structure of data maintained by the MCEs' self-reported compliance with Heritage Health contract standards for geographic access to care. The CY 2022–2023 NAV activities aligned with three general project phases described in Figure 3-1.

Figure 3-1—Summary of NAV Project Phases and Tasks



Technical Methods of Data Collection

DHHS Member and Known Provider Data

To conduct the NAV analysis, HSAG requested Medicaid member files from DHHS. To define the requested data, HSAG submitted a detailed member data requirements document to DHHS and hosted a technical assistance call to review the data request in detail and clarify any questions regarding the data request. The member data requirements document included a template detailing fields to be included, field descriptions, naming conventions, and formats.

Upon receiving the member and known provider data files from DHHS, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. Submitted data elements

underwent a series of rigorous quality control (QC) examinations to ensure data were representative, complete, and accurate. HSAG provided DHHS with the results of this review and requested resubmission of files as needed.

MCE Provider Network Data

To conduct the NAV analysis, HSAG requested provider network data files from the MCEs. To define the requested data, HSAG submitted a detailed provider data requirements document to the MCEs and hosted a technical assistance call to review the data request in detail and clarify any questions regarding the data request. The provider network data requirements document included a template detailing fields to be included, field descriptions, naming conventions, and formats.

Upon receiving the MCOs' and DBM's provider network data files, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. Submitted data elements underwent a series of rigorous QC examinations to ensure data were representative, complete, and accurate. HSAG provided the MCOs and DBM with the results of the data review, including any questions that need clarification. The MCOs and DBM were requested to resubmit files as needed.

Description of Data Obtained

DHHS Member and Known Provider Data

HSAG requested data for members actively enrolled in an MCO or the DBM as of June 1, 2022, a date determined in collaboration with DHHS. Key data elements requested included, but were not limited to, each member's street address, city, state, ZIP Code, dates of enrollment, and MCO and/or DBM affiliation. HSAG also requested data for all known ordering, referring, servicing, and billing Medicaid providers enrolled with Nebraska Heritage Health as of June 1, 2022. Key data elements requested included, but were not limited to, national provider identifier (NPI), provider type and specialty, provider taxonomy, and provider address.

MCE Provider Network Data

HSAG submitted a detailed data requirements document for the provider data to the MCOs and the DBM for providers actively enrolled as of June 1, 2022, a date identified in collaboration with DHHS. HSAG supplied the MCOs and the DBM with instructions consistent with existing methods for classifying providers into categories for the geographic access analysis. Key data elements requested included, but were not limited to, unique provider identifier, enrollment status with the MCOs or DBM, provider category, provider type, provider specialty, taxonomy code, and indicator flags to identify different provider categories such as primary care providers (PCPs), high-volume specialists, and dental specialists.

How Data Were Aggregated and Analyzed

HSAG used the Medicaid member files from DHHS and the MCE provider network data to perform the NAV analysis. The NAV analysis evaluated two dimensions of access and availability:

- **Network Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of providers associated with the MCE's provider network relative to the number of enrolled members. This provider-to-member ratio (provider ratio) represented a summary statistic used to highlight the overall capacity of an MCE's provider network to deliver services to Medicaid members.
- **Geographic Network Distribution Analysis:** The second dimension of this study evaluated the geographic distribution of the providers relative to member populations. For each MCE and county, HSAG calculated the percentage of members with the required access as defined in the DHHS Quality Strategy 2020. HSAG also calculated the average distance to the first and second closest providers of each type for members with and without the required access.

Network Capacity Analysis

HSAG calculated the provider ratio for each provider category included in the analysis for the MCOs and DBM. Specifically, the provider ratio measured the number of providers by provider category (e.g., PCPs, high-volume specialists, pharmacies, and hospitals) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available[3-6] to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations. Because provider ratio standards were not defined as part of the DHHS Quality Strategy 2020, the results of this analysis were descriptive only and were not intended as an evaluation of MCEs for meeting or failing to meet specific standards.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to the MCOs' and DBM's members. While the network capacity analysis identified whether the network infrastructure was sufficient in both number of providers and variety of provider types, the geographic network distribution analysis evaluated whether the provider locations in an MCO's or the DBM's provider network were proportional to their respective Medicaid member population.

To provide a comprehensive view of geographic access, HSAG calculated the following spatially-derived metrics for the provider categories with geographic access standards:

- Percentage of members with required access according to standards:[3-7] A higher percentage of members meeting access standards indicates better geographic distribution of an MCO's or the

[3-6] The availability based on provider ratio did not account for key practice characteristics—i.e., panel status, acceptance of new patients, or practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

[3-7] The percentage of members within predefined standards was only calculated for provider categories with predefined access standards.

DBM's providers in relation to its Medicaid members. This metric was calculated for any provider categories for which DHHS has identified a geographic access standard prior to initiation of the analysis and ascertained the extent to which each plan was meeting applicable standards.

- Average travel distance (driving distance in miles) or travel time[3-8] (in minutes) for providers with travel time standards, to the nearest one to two providers: A smaller distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

HSAG used software from Quest Analytics to calculate the travel time or physical distance between the addresses of specific members and the addresses of their nearest one to two providers for all provider categories identified in the analysis. All study results were stratified by MCO and DBM, as well as by county. Table 3-8 shows the provider categories that were used to assess the MCOs' and DBM's compliance with the geographic access standards.

Table 3-8—Provider Categories, County Urbanicity, and Time-Distance Standards

Provider Category	County Urbanicity	Geographic Access Standard
MCO Geographic Access Standards		
Primary care providers	Urban	2 providers within 30 miles
	Rural	1 provider within 45 miles
	Frontier	1 provider within 60 miles
High-volume specialists	All counties	1 provider within 90 miles
Pharmacy	Urban	90 percent of members within 5 miles
	Rural	70 percent of members within 15 miles
	Frontier	70 percent of members within 60 miles
Behavioral health inpatient and residential service providers	Rural and Frontier	Sufficient locations to allow members to travel to provider and return home within a single day[1]
Behavioral health outpatient assessment and treatment provider	Urban	Adequate choice within 30 miles[2]
	Rural	2 providers within 45 miles[3]
	Frontier	2 providers within 60 miles[3]
Hospitals	All counties	30 minutes' drive time[4]

[3-8] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times were estimated by Quest Analytics based on the following drive speeds: urban areas were estimated at a drive speed of 30 miles per hour, suburban areas were estimated at a drive speed of 45 miles per hour, and rural areas were estimated at a drive speed of 55 miles per hour.

Provider Category	County Urbanicity	Geographic Access Standard
DBM Geographic Access Standards		
Dentists	Urban	2 providers within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Oral Surgeons	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Orthodontists	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Periodontist	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles
Pediadontist	Urban	1 provider within 45 miles
	Rural	1 provider within 60 miles
	Frontier	1 provider within 100 miles

[1] HSAG confirmed with DHHS that this standard should be evaluated as "1 provider within 240 miles" or a 480-mile round trip within a single day.

[2] HSAG collaborated with DHHS to determine that this standard should be evaluated as "2 providers within 30 miles" based on comparable standards in other EQRO states.

[3] If rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must use telehealth options. At the time of this study, DHHS had not determined any rural or frontier county network to be deficient for this provider category.

[4] In rural areas, hospital access time may be greater than 30 minutes. If greater, the standard needs to be the community standard for accessing care, and the exceptions must be justified and documented to the State on the basis of community standards. At the time of this study, DHHS had not identified any rural county wherein usual and customary transport time exceeded 30 minutes.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about MCE performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Nebraska Heritage Health member access to particular provider networks (e.g., primary, specialty, or dental health care) in specified geographic regions. The data also allow HSAG to draw conclusions regarding the quality of the MCEs' ability to track and monitor their respective provider networks.

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

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

NAV Activities	Quality	Timeliness	Access
Network Capacity Analysis—Provider Ratios	✓	✓	✓
Geographic Network Distribution Analysis—Percentage of Members With Access According to Standards		✓	✓

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 2022–2023 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 one PIP, *Plan All-Cause Readmissions*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions (PCR)* measure, for the 2022–2023 validation cycle. The PIP received an overall *Partially Met* validation status for the initial submission. **HBN** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table A-1 summarizes **HBN**'s PIP validation scores.

Table A-1—2022–2023 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
Plan All-Cause Readmissions (PCR)	Initial Submission	67%	78%	*Partially Met*
	Resubmission	90%	100%	*Met*

Overall, 90 percent of all applicable evaluation elements received a score of *Met*. Table A-2 presents baseline and Remeasurement 1 performance indicator data for **HBN**'s *Plan All-Cause Readmissions* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

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

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 150	7.74%	N: 162	10.51%	*Not Assessed*
	D: 1,937		D: 1,542		

N–Numerator D–Denominator

For the baseline measurement period, **HBN** reported that 7.74 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. For the first remeasurement period, **HBN** reported that 10.51 percent of inpatient discharges

for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of discharge. The increase in the total observed readmission rate of 2.77 percentage points represented a decline in indicator performance from baseline to Remeasurement 1.

Interventions

For the *Plan All-Cause Readmissions (PCR)* PIP, **HBN** used readmissions data, workgroup discussion, intervention evaluation results, and drill-down analyses to identify the following barriers and interventions to improve performance indicator outcomes.

Table A-3 displays the barriers to improvement that **HBN** identified and the interventions **HBN** initiated to address those barriers.

Table A-3—Barriers and Interventions for HBN's *Plan All-Cause Readmissions* PIP

Barriers	Interventions
Poor care transitions	• Targeted high-risk member outreach conducted by **HBN**'s Post Discharge Management program to assist members with appointment scheduling and medication management, and to support compliance with the discharge care plan. • Enrollment of high-risk members into the Care Management program to assist with transition of care.
Social determinants of health barriers	Use of the Find Help platform by **HBN** staff members to assist members in identifying and accessing community and social resources to address needs related to job and income insecurity, transportation, language needs, housing, and food instability.
Inadequate access to care	• Identification of high-volume provider groups that offer telehealth services for members. • LiveHealth Online service for members to address physical and behavioral health needs, and to assist with diagnosis, prescription, and care instructions.
Mental illness	• Member outreach within seven days of an emergency department (ED) visit or inpatient stay discharge, to ensure a follow-up appointment is scheduled and to address any barriers to attending the appointment. • Member educational outreach to all members with an ED visit or inpatient stay discharge on the behavioral health hotline available 24/7 for all members.
Health disparities	List provider ethnicity details in provider directories for members to support informed provider selection.

Strengths

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

- **HBN** followed a methodologically sound PIP design for the baseline and Remeasurement 1 periods that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **HBN** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **HBN** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

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

- **HBN** reported indicator results that demonstrated a decline in performance from baseline to Remeasurement 1. **[Quality]**

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

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

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

Table A-4 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table A-4—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
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.

Response
Describe initiatives implemented based on recommendations: **HBN** requested technical assistance from HSAG for further education on statistical testing for the Plan All Cause Readmission (PCR) PIP. After identifying the error being made by **HBN**, statistical testing was completed using the Chi-Squared method as recommended by HSAG.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: The transition from WellCare to **HBN** resulted in delayed data retrieval, as well as member and provider outreach and education efforts. COVID-19 also impacted this measure throughout the measurement period.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will request technical assistance from HSAG if statistical testing concerns are noted in future PIP reporting.
Recommendations
Use plan-do-study-act (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.
Response
Describe initiatives implemented based on recommendations: Based on quarterly review of PIP data at the end of 2021, **HBN** made changes to the PCR PIP interventions. **HBN** will continue to utilize findhelp, **HBN**'s community resource tool, to help members find solutions to their social determinants of health (SDoH) needs. Moving forward, **HBN** will increase marketing of this tool through care management, member materials, and provider education. **HBN** will support community partners to help ensure they are best equipped to serve members. **HBN** will continue to offer LiveHealth Online (LHO) to all members to increase access to health care and remove barriers members face. Moving forward, **HBN** will also provide kiosks with LHO and translation services in area Welcome Rooms, provider offices, and community partner offices to help provide better access to this service. **HBN**'s Patient Centered Care Consultants will identify the number of high member attribution provider groups that offer tele-health options, obtain detail of their offering, and educate members in need of telehealth services through our member outreach campaigns.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As referenced above, initiatives are in place to support measure improvement and results monitoring going forward. **HBN** monitors all PIP initiatives on a quarterly basis, reviewing the results of each intervention. The Quality team consults with Market leaders to review the efficacy of interventions and identify opportunities to expand, revise, or replace interventions to improve outcomes. PIP data is shared in Quality Management (QM) and Clinical Committees and recommendations are solicited from committee members to improve the interventions and outcomes for each PIP.
Identify any barriers to implementing initiatives: The transition from WellCare to **HBN** resulted in delayed data retrieval, as well as member and provider outreach and education efforts. COVID-19 also impacted this measure throughout the measurement period.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to review PIP intervention data quarterly within appropriate workgroups and committees.

Recommendations
Revisit causal/barrier analyses at least annually to ensure that the identified barriers and opportunities for improvement are still applicable.
Response
Describe initiatives implemented based on recommendations: Based on our quarterly review of PIP barrier analysis at the beginning of 2022, **HBN** added the following intervention to the PCR PIP. **HBN** will work to identify health care disparities leading to readmission to drive interventions towards the identified population for all members by encouraging providers to add their ethnicity to the **HBN** roster so that members can sort potential providers by the ethnicity they feel most comfortable seeing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As referenced above, initiatives are in place to support measure improvement and results monitoring going forward. **HBN** reviews each PIP causal/barrier analysis on a quarterly basis. The Quality team consults with Market leaders to review the efficacy of interventions and identify opportunities to expand, revise, or replace interventions to improve outcomes. PIP data is shared in QM and Clinical Committees to solicit recommendations from committee members to improve the interventions and the outcomes for each PIP.
Identify any barriers to implementing initiatives: There were a low number of providers who initially provided their ethnicity information when completing the credentialing process with **HBN**. The transition from WellCare to **HBN** resulted in delayed data retrieval, member education, and provider education. The COVID-19 pandemic also continued to impact this measure.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to review PIP intervention data quarterly and review within appropriate workgroups and committees. **HBN** Provider Experience and **HBN** Network Management have teamed up to encourage submission of ethnicity information from new providers and current providers to update their provider roster to increase the number of provider ethnicities to place on **HBN** provider look up tool.
Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses as part of the causal/barrier analyses.
Response
Describe initiatives implemented based on recommendations: **HBN** utilized a fishbone diagram to identify gaps and prioritize barriers for the PCR PIP. As a result of developing the fishbone diagram for the **HBN** PCR PIP, as well as feedback from **HBN**'s Member Advisory Group (MAG), **HBN** identified that lack of transparency regarding provider ethnicity may be causing higher readmission rates due to members not feeling comfortable with their current PCP or not having a PCP. At that time, **HBN** added the following intervention at the beginning of 2022: **HBN** will work to identify health care disparities leading to readmission to drive interventions towards the identified population for all members by encouraging providers to add their ethnicity to the **HBN** roster so that members can sort potential providers by the ethnicity they feel most comfortable seeing. **HBN** reviews each PIP causal/barrier analysis on a quarterly basis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As referenced above, causal analysis and identification of gaps and barriers was completed and continues on a quarterly basis. Initiatives are in place to support measure improvement and results monitoring going forward. The Quality team consults with Market leaders to review the efficacy of interventions and identify opportunities to expand, revise, or replace interventions to improve outcomes. PIP data is shared in QM and Clinical

Committees to solicit recommendations from committee members to improve the interventions and the outcomes for each PIP.
Identify any barriers to implementing initiatives: There were a low number of providers who included their ethnicity information when initially credentialling with **HBN**. The transition from WellCare to **HBN** resulted in delayed data retrieval, member education, and provider education. COVID-19 also impacted this measure.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to review PIP intervention data quarterly and review within appropriate workgroups and committees. **HBN** Provider Experience and **HBN** Network Management are collaborating to encourage both new and current providers to include their ethnicity information when credentialing or updating their provider rosters in order to increase the number of provider ethnicities included in the **HBN** provider look up tool.

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 2021 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-5—Summary of Compliance With IS Standards for HBN

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 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 steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	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.
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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
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. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**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.
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.	**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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 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. • Data approved for ECDS reporting met reporting requirements. • NCQA validated data resulting from the DAV program met reporting requirements.	
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.
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-certified measure 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-6 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*" status for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table A-6—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***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table A-7—HBN's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
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% ★★	73.72% ★★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	68.61% ★★★	64.72% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	64.48% ★★★	61.31% ★★★	R
CIS: Childhood Immunization Status—Combination 3	70.80% ★★★★	72.99% ★★★★★	R
CIS: Childhood Immunization Status—Combination 7	—	64.72% ★★★★★	R
CIS: Childhood Immunization Status—Combination 10	47.69% ★★★★★	54.26% ★★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	75.18% ★★★	77.13% ★★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	—	31.14% ★★★	R
LSC: Lead Screening in Children	72.26% ★★★★	70.80% ★★★★	R
BCS: Breast Cancer Screening	40.62% ★	42.69% ★★	R
CCS: Cervical Cancer Screening	63.99% ★★★★★	58.88% ★★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	29.24% ★	26.60% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	40.39% ★	37.70% ★	R
CHL: Chlamydia Screening in Women—Total	32.97% ★	30.90% ★	R
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	73.83% ★★	74.12% ★★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	63.57% ★★★	65.29% ★★★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65 and Older	NA	NA	R
CWP: Appropriate Testing for Pharyngitis—Total	72.20% ★★★	71.81% ★★★★	R
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.30% ★★	28.00% ★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	34.02% ★	56.29% ★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	43.44% ★	71.86% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
AMR: Asthma Medication Ratio—Ages 5 to 11	72.64% ★★	75.36% ★★★	R
AMR: Asthma Medication Ratio—Ages 12 to 18	58.84% ★	62.07% ★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	55.49% ★★★	60.92% ★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	59.46% ★★★★	61.36% ★★★★	R
AMR: Asthma Medication Ratio—Total	63.42% ★★★	66.04% ★★★★	R
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure—Controlling High Blood Pressure	52.80% ★★★	53.04% ★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	65.91% ★	R
Effectiveness of Care: Diabetes			
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	84.91% ★★★★	88.81% ★★★★★	R
*CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	45.74% ★★★	40.88% ★★★	R
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	45.01% ★★★	48.66% ★★★	R
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.07% ★★★★	50.61% ★★★	R
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.02% ★★★★	66.18% ★★★★	R
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.99% ★★★	61.69% ★★★★	R
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	40.25% ★★★	47.66% ★★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	44.11% ★★★	38.99% ★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	56.72% ★★★★	46.78% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	55.00% ★★★★	44.95% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	75.00% ★★★★	70.41% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	34.57% ★★★★	34.25% ★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	54.26% ★★★★	53.59% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	42.19% ★★★★	37.60% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.17% ★★★★	58.86% ★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	41.79% ★★★★	40.91% ★★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	61.59% ★★★★	59.25% ★★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—Total	27.43% ★★★	23.24% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	42.29% ★★★	43.37% ★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence — 7-Day Follow-Up—Total	11.04% ★★★	13.96% ★★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence — 30-Day Follow-Up—Total	14.05% ★★★	23.42% ★★★★	R
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.25% ★★	76.78% ★★★	R
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	53.19% ★	48.86% ★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.61% ★★★	52.89% ★★	R
Effectiveness of Care: Overuse/Appropriateness			
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.31% ★★★★	0.20% ★★★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	88.71% ★★	90.20% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years	77.84% ★★★	80.47% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older	94.32% ★★★★★	NA	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
URI: Appropriate Treatment for Upper Respiratory Infection—Total	87.51% ★★★	88.75% ★★★	R
LBP: Use of Imaging Studies for Low Back Pain—Use of Imaging Studies for Low Back Pain	76.84% ★★★★	76.89% ★★★★	R
*HDO: Use of Opioids at High Dosage**	4.75% ★★★★	2.06% ★★★★	R
Access/Availability of Care			
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17	59.51% ★★★★★	33.62% ★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17	25.37% ★★★★★	12.50% ★★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 18 and Older	54.16% ★★★★★	41.82% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 18 and Older	16.43% ★★★★	12.27% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total	54.88% ★★★★★	41.12% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD—Total—Total	17.62% ★★★★	12.29% ★★★	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.32% ★★★	76.16% ★★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	77.13% ★★★★	68.37% ★★	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% ★★★★★	60.83% ★★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	72.67% ★★★★	66.85% ★★★★	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^*	0.00 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^*	0.00 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^*	0.00 NC	0.02 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^*	0.00 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^*	0.09 NC	0.16 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^*	0.20 NC	0.39 NC	R
*FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^*	0.60 NC	0.58 NC	R
*FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^*	0.26 NC	0.31 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^*	0.10 NC	0.05 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^*	0.14 NC	0.18 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—15–44 Years—Female^*	0.17 NC	0.11 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^*	0.17 NC	0.09 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^*	0.00 NC	0.01 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^*	0.01 NC	0.01 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^*	0.03 NC	0.07 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^*	0.34 NC	0.30 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^*	0.76 NC	0.77 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^*	0.51 NC	0.73 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^*	0.46 NC	0.36 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^*	0.80 NC	0.81 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^*	0.20 NC	0.16 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
*FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^*	1.06 NC	0.77 NC	R
*FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^*	0.05 NC	0.03 NC	R
*FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^*	0.31 NC	0.26 NC	R
*FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^*	0.11 NC	0.10 NC	R
*FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^*	0.40 NC	0.26 NC	R
AMB: Ambulatory Care (Per 1,000 Member Months)—Emergency Department Visits—Total^, *	36.29 ★★★★	44.38 ★★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^*	293.10 NC	324.28 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^*	7.82 NC	5.75 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total All Ages	4.60 NC	7.32 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total All Ages^*	5.52 NC	3.78 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total All Ages	2.41 NC	2.45 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total All Ages^*	1.28 NC	1.03 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total All Ages	9.00 NC	9.15 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total All Ages^*	3.66 NC	2.40 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total All Ages	4.77 NC	11.25 NC	R
Risk Adjusted Utilization			
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	10.51% NC	11.33% NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.27% NC	10.40% NC	R
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	0.93 ★★★★	1.09 ★★	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 2021 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 or the rate was not displayed in the previous year.
* For this indicator, a lower rate indicates better performance.
HEDIS MY 2021 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-8—HBN's CMS Core Set Measure Rates

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
Adult Core Measures		
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 18 to 64**	—	17.58%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 65+**	—	22.22%
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	—	32.85%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—18 to 64**	—	3.09%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—65+**	—	3.45%
*PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,00 Member Months)**	—	1.43
Child Core Measures		
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^*	58.28	74.65
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^*	23.93	32.61
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—10 to 19^*	20.95	24.56

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—Total^	—	31.51
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 1 Year	—	21.02%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 2 Years	—	30.45%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 3 Years	—	26.61%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	26.13%

The MCO's CMS Adult and Child Core measures were not required to be audited and are presented for information only.
^ Rate is reported per 1,000 beneficiary months rather than a percentage.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*, *Lead Screening in Children*, and *Cervical Cancer Screening* measure indicators were a strength for **HBN**. For the *Childhood Immunization Status* measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 75th percentile benchmark, while the *Lead Screening in Children* and *Cervical Cancer Screening* measure indicators ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. The *Childhood Immunization Status—Combination 3*, *Combination 7*, 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] Finally, the *Lead Screening in Children* measure indicator demonstrates children under 2 years of age are adequately receiving a lead blood test to ensure they are maintaining limited exposure to lead. **[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: Nov 1, 2022.

[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 July 30. Available at: https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html. Accessed on: Nov 1, 2022.

Effectiveness of Care: Respiratory Conditions Domain

The *Asthma Medication Ratio—Ages 19 to 50*, *Ages 51 to 64*, and *Total* measure indicators were a strength for **HBN**. For these measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. These rates indicate that **HBN** providers are handling asthma appropriately for these age groups 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]**

The *Appropriate Testing for Pharyngitis—Ages 18 to 64* and *Total* measure indicators were also a strength for **HBN**. For these measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. These rates indicate that **HBN** providers are appropriately testing to warrant antibiotic treatment for these members with a diagnosis for pharyngitis. **[Quality]**

For the *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure, **HBN**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. **HBN** 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

HSAG did not identify any strengths when conducting the PMV for **HBN** within the Effectiveness of Care: Cardiovascular Conditions domain.

Effectiveness of Care: Diabetes Domain

The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were a strength for **HBN**. For these measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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]**

[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: Nov 1, 2022.

[A-5] Centers for Disease Control and Prevention (CDC). 2020. "National diabetes statistics report, 2020." Atlanta, GA: U.S. Department of Health and Human Services. Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html. Accessed on: Nov 1, 2022.

Effectiveness of Care: Behavioral Health Domain

For the following measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64* and *30-Day Follow-Up—Ages 18 to 64*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

Based on these rates, **HBN** 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). Also, **HBN** 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. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions,[A-6,A-7,A-8] while timely follow-up care for individuals with AOD who were seen in the ED is associated with a reduction in substance use, future ED use, and hospital admissions.[A-9,A-10,A-11] **[Quality, Timeliness, and Access]**

[A-6] Griswold, K.S., Zayas, L.E., Pastore, P.A., Smith, S.J., Wagner, C.M., Servoss, T.J. (2018) Primary Care After Psychiatric Crisis: A Qualitative Analysis. *Annals of Family Medicine*, *6(1), 38-43*. doi:10.1370/afm.760.

[A-7] Kyriacou, D.N., Handel, D., Stein, A.C., Nelson, R.R. (2005). Brief Report: Factors Affecting Outpatient Follow-up Compliance of Emergency Department Patients. *Journal of General Internal Medicine, 20(10), 938-942*. doi:10.1111/j.1525-1497.2005.0216_1.x.

[A-8] Bruffaerts, R., Sabbe, M., Demyffenaere, K. (2005). Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *General Hospital Psychiatry, 27, 269-74*.

[A-9] Kunz, F.M., French, M.T., Bazargan-Hejazi, S. (2004). Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. *Journal of Studies on Alcohol and Drugs, 65, 363-370*.

[A-10] Mancuso, D., Nordlund, D.J., Felver, B. (2004). Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division.

[A-11] Parthasarathy, S., Weisner, C., Hu, T.W., Moore, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. *Journal of Studies on Alcohol and Drugs, 62, 89–97*.

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**. For these measures, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-12] 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**. For this measure, **HBN**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-13]Of those, 40 percent involved prescription opioids.[A-24] Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose.[A-14,A-15,A-16] **[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 **HBN**. For this measure indicator, **HBN**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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]**

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 in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators were a strength for **HBN**.

[A-12] 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: Nov 1, 2022.

[A-13] 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: Nov 1, 2022.

[A-14] 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-15] 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-16] 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.

For these measure indicators, **HBN**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. This indicates children within the first 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**. For this measure indicator, **HBN**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark, suggesting appropriate utilization of services.

Risk Adjusted Utilization Domain

HSAG did not identify any strengths when conducting the PMV for **HBN** within the Risk Adjusted Utilization domain.

Measures Reported Using ECDS Domain

HSAG did not identify any strengths when conducting the PMV for **HBN** within the Measures Reported Using ECDS domain.

Summary Assessment of Opportunities for Improvement and Recommendations

Effectiveness of Care: Prevention and Screening Domain

The *Breast Cancer Screening* measure was a weakness for **HBN**. For this measure, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th 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 continued to recommend 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 continuation of the COVID-19 PHE, 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 also a weakness for **HBN**. For these measure indicators, **HBN**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including 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-17] HSAG continued to recommend that **HBN** providers follow up annually with sexually active members through any type of communications such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuation of the COVID-19 PHE, 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 12 to 18* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators were a weakness for **HBN**. For these measure indicators, **HBN**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-18] HSAG continued to recommend 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 rates, **HBN** providers are not appropriately prescribing 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-19] However, symptoms can be controlled with appropriate medication.[A-20,A-21] Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. HSAG continued to recommend 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]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* and *Persistence of Beta-Blocker Treatment After a Heart Attack* measures were weaknesses for **HBN**. For these measures, **HBN**'s rates ranked at or below NCQA's

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[A-17] 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-18] 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: Nov 1, 2022.

[A-19] 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-20] National Heart, Lung, and Blood Institute. 2012. "Morbidity and Mortality: 2012 Chart Book on Cardiovascular, Lung, and Blood Diseases."

[A-21] Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, and Prevention of Chronic Obstructive Pulmonary Disease."

Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. The *Controlling High Blood Pressure* measure rate indicates that **HBN** providers are not handling the monitoring and controlling of members' blood pressure appropriately 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.[A-22] HSAG recommended **HBN** conduct a root cause analysis to ensure providers are working with members who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) and identify any areas of evaluation that might be missed by the providers during member visits. **[Quality]**

In addition, the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure rate indicates adults 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction were not appropriately receiving persistent beta-blocker treatment for six months after discharge. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring.[A-23] Beta-blockers work by lowering the heart rate. This reduces the amount of force on the heart and blood vessels.[A-24] HSAG recommended **HBN** conduct a root cause analysis as to ensure providers are working with members who were discharged with a diagnosis of acute myocardial infarction and identify any areas of evaluation that might be missed by the providers during member visits to ensure treatment is being addressed and issued appropriately. **[Quality]**

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the Effectiveness of Care: Diabetes domain.

Effectiveness of Care: Behavioral Health Domain

The *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measures were a weakness for **HBN**. For these measures, **HBN**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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

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[A-22] National Committee for Quality Assurance. *Controlling High Blood Pressure*. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Nov 1, 2022.

[A-23] Yancey, C.W., M. Jessup, B. Bozkurt, J. Butler, D.E. Casey, M.H. Drazner, G.C. Fonarow, et al. 2013. "ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines." Circulation 128:e240–e327.

[A-24] AHA. 2013. "How do beta blocker drugs affect exercise?" Available at: http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/How-do-beta-blocker-drugs-affect-exercise_UCM_450771_Article.jsp. Accessed on: Nov 1, 2022.

health and death.[A-25] HSAG continued to recommend 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**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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 continued to recommend 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-26] In addition, HSAG continued to recommend 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 measure indicator was a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care.[A-27] HSAG recommended that **HBN** work with its providers to ensure they are reaching members with identified SUD and to engage in follow-up treatment. **HBN** 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* and *Postpartum Care* measure indicators were also a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark.

[A-25] 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: Nov 1, 2022.

[A-26] 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: Nov 1, 2022.

[A-27] National Library of Medicine. Patient Characteristics Associates with Treatment Initiation and Engagement Among Individuals Diagnosed with Alcohol and Other Drug Use in the Emergency Department and Primary Care Settings. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6669120/. Accessed on: Nov 1, 2022.

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-28] 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-29] HSAG recommended that **HBN** work with its providers on best practices for providing ongoing prenatal care. This is especially important during the continuation of the COVID-19 PHE, as pregnant and recently pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women.[A-30]**[Quality, Timeliness, and Access]**

Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the Utilization domain.

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **HBN**. For this measure indicator, **HBN**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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 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.[A-31] HSAG recommended that **HBN** work with its providers to ensure diagnosis and treatment of members are complete and precise in order to improve readmission rates. **[Quality]**

Measures Reported Using ECDS Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **HBN** within the Measures Reported Using ECDS domain.

[A-28] CDC Review to Action. (2018). Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Retrieved from: http://reviewtoaction.org/Report_from_Nine_MMRCs.

[A-29] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

[A-30] 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: Nov 1, 2022.

[A-31] 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.

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

Table A-9 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table A-9—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for 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. 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 the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services. • 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. • 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. HSAG recommended that **HBN** providers follow up annually with sexually active members through any type of communication to ensure members return for yearly screening.
Response
Describe initiatives implemented based on recommendations: *The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total*: **HBN** implemented a text/mail/call campaign to outreach members who need a well-child check. **HBN** also has a Care Delivery Transformation (CDT) Team that conducts outreach and education to provider groups as it relates to suggested coding to close gaps and proper medical record documentation. *Breast Cancer Screening*: **HBN** implemented text/call campaigns to outreach to members who need a breast cancer screening. Eligible **HBN** members can earn a Healthy Reward incentive after they have completed their breast cancer screening. In 2021, **HBN** waived any referral requirements for mammograms. *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years*, and *Total*: **HBN** implemented a texting campaign to outreach to members who need cervical cancer screening.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): *The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total*: **HBN** continues to work toward electronic connectivity with all provider groups. To date, **HBN**'s value-based contracted (VBC) groups have access to **HBN**'s Provider Centered Management System (PCMS), which allows groups to track their own performance and identified gaps in care. In addition, **HBN** has established electronic connectivity with two additional providers, and work is underway to establish electronic connectivity for five additional providers before the end of 2022.

Breast Cancer Screening: As a result of the implementation of the above initiatives, **HBN** noted an improvement for this measure of 2.07 percentage points from 2020 to 2021.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: Not applicable.

Identify any barriers to implementing initiatives: *The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total*: A low number of providers have historically submitted CPT-II codes on claims. This measure includes three components, and the primary source of capture is hybrid review, which consists of manual medical record review.

Breast Cancer Screening: The transition from WellCare to **HBN** resulted in delayed data retrieval, member education, and provider education. The COVID-19 pandemic also impacted this measure.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: The transition from WellCare to **HBN** resulted in delayed data retrieval, member education, and provider education. COVID-19 also impacted this measure.

Identify strategy for continued improvement or overcoming identified barriers: *The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total*: **HBN** is working to increase the number of connected provider electronic medical record (EMR) systems, establish access to EMR flat files via secure file transfer protocol (SFTP) agreements and the Nebraska Health Information Exchange (HIE), and will continue provider education efforts, gaps in care reports, and quality resources.

Breast Cancer Screening: **HBN** will continue to create heat maps for this population to identify geographic areas and ethnicities who may be impacted by social determinates of health preventing them from completing their breast cancer screenings in order to better allow future interventions to positively impact this rate.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: **HBN** will continue to educate members and providers through texting campaigns, MAG meetings, provider townhalls, and individual outreach to providers.

Recommendations for 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.
- 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.
- 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. 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. However, symptoms can be controlled with appropriate medication. 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).
Response
Describe initiatives implemented based on recommendations: The *Appropriate Testing for Pharyngitis—Ages 3 to* 17: **HBN**'s Care Consultant Team is leading an effort to educate providers, including helpful tips as suggested by NCQA technical specifications. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*: **HBN** provides focused care management efforts for COPD members. In March 2021, **HBN**'s Provider Newsletter included an educational article promoting the Disease Management/Population Health Programs for members who have a diagnosis of COPD. Communication was sent to providers with a newly diagnosed member that had not had a spirometry test confirming their diagnosis in 2021. The communication educated the provider on proper documentation and coding of both testing and diagnosis for members. *Asthma Medication Ratio—Ages 5 to 11 and Ages 12 to 18*: **HBN** is engaged in focused care management efforts for asthmatic members. An educational article was published in the Provider Newsletter promoting Disease Management/Population Health Programs for members who have a diagnosis of asthma. A call campaign was initiated for members who recently started on an asthma control medication, have a new diagnosis, or have recently filled a rescue medication. Calls are made by a technician or pharmacist. Also initiated were fax and mailing campaigns to providers caring for members who are newly started on an asthma control medication, have a new diagnosis, or have recently filled a rescue medication. *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*: **HBN** has a COPD Post Discharge Program. As part of this program, **HBN** contracted pharmacies to send fax communications to prescribers and conducts a call campaign to both providers and members.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *Appropriate Testing for Pharyngitis—Ages 3 to* 17: **HBN** has shown an improvement of 2.09 percentage points from 2020 to 2021. In addition, the goal of reaching or exceeding the 66.67th percentile was achieved by 0.50 percentage points. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*: None noted at the time of the submission of this report, but monitoring is ongoing to track future improvements. *Asthma Medication Ratio—Ages 5 to 11 and Ages 12 to 18*: **HBN** noted an improvement for members 5–18 years of age by 2.64 percentage points from 2020–2021. Monitoring is ongoing for both age groups.

Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and *Bronchodilator*: Both PCE measures showed improvement in 2021 from the 2020 rates. Improvement from 2020 was most notable for Bronchodilator by 14.07 percentage points, while Systemic Corticosteroid improved by 7.25 percentage points.
Identify any barriers to implementing initiatives: *Appropriate Testing for Pharyngitis—Ages 3 to 17*: Properly educating members continues to be a barrier on the difference between viral and bacterial infections and appropriate treatment for each. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*: The transition from WellCare to **HBN** resulted in delayed data, member education, and provider education. COVID-19 continued to impact this measure. *Asthma Medication Ratio—Ages 5 to 11* and *Ages 12 to 18*: The transition from WellCare to **HBN** resulted in delayed data, member education, and provider education. COVID-19 also continued to impact this measure. *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*: This measure is time sensitive (within 30 days for bronchodilator and 14 for systemic corticosteroid) based on acute inpatient discharges and ED visits making it difficult to proactively capture and pursue members within this threshold.
Identify strategy for continued improvement or overcoming identified barriers: *Appropriate Testing for Pharyngitis—Ages 3 to* 17: **HBN** provides provider education, record reviews for members with open care gaps, and continues to monitor rates for this measure. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*: **HBN** continues to monitor and identify opportunities for improvement. *Asthma Medication Ratio—Ages 5 to 11 and Ages 12 to 18*: **HBN**'s member pharmacy call campaign for asthmatic members targets members who have not refilled their medication, as well as members newly diagnosed with asthma, for interventions on the AMR measure. *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and Bronchodilator: **HBN** continues to monitor and identify opportunities for improvement.
Recommendations 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. 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.

Response
Describe initiatives implemented based on recommendations: In 2021, **HBN** recruited providers to participate in a Behavioral Health Quality Initiative Program (BHQIP). Part of the BHQIP is a focus on *People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People With Diabetes and Schizophrenia* (*SSD*) and encouraging this population to get an annual diabetic screening. In 2021, **HBN** created provider educational materials related to the *SSD* measure. **HBN** initiated a project to provide tape measures and instructions on how to measure a member's body mass index (BMI) and discuss the importance of BMI while on anti-psychotic medication. This project was implemented in 2022. Additionally, **HBN**'s national team conducted a record review on all members in this population with an open care gap for *SSD* who had an inpatient or emergency room visit to review whether the appropriate labs were completed but not captured.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HBN noted an increase in the *SSD* rate by 3.53 percentage points from 2020 to 2021.
Identify any barriers to implementing initiatives: The transition from WellCare to **HBN** resulted in delayed data retrieval, member education and provider education. COVID-19 also impacted this measure.
Identify strategy for continued improvement or overcoming identified barriers: HBN will continue outreach to all members placed on an antipsychotic medication to encourage the appropriate metabolic testing is completed and is adding a text campaign to this outreach effort. **HBN** will educate providers on the *SSD* measure as needed and the plan will review data for outliers, providers who have a high rate of prescribing antipsychotic medication and not performing the proper metabolic testing, so direct follow-up can be completed. **HBN** will continue to review records annually for members with an open *SSD* care gap who also had an inpatient or emergency room stay to ensure *SSD* data is captured.
Recommendations for 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. 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.
Response
Describe initiatives implemented based on recommendations: HBN has included the measure, *Appropriate Treatment for Upper Respiratory Infection*, as an option for provider value-based contracts.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HBN noted improvement from 2020 to 2021 by 2.94 percentage points as a result of this initiative.
Identify any barriers to implementing initiatives: Properly educating members on the difference between viral and bacterial infections and appropriate treatment.
Identify strategy for continued improvement or overcoming identified barriers: HBN's pharmacy vendor, IngenioRX has a medication review and note program including antibiotic overuse and upper respiratory infection messaging to providers that is currently in the review process and will be implemented once finalized.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

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

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**HBN Results**	
Standard I—Enrollment and Disenrollment	100%	100%
Standard II—Member Rights and Confidentiality	83%	
Standard III—Member Information	77%	
Standard IV—Emergency and Poststabilization Services	100%	100%
Standard V—Adequate Capacity and Availability of Services	86%	
Standard VI—Coordination and Continuity of Care	100%	
Standard VII—Coverage and Authorization of Services	84%	
Standard VIII—Provider Selection and Program Integrity	94%	94%
Standard IX—Subcontractual Relationships and Delegation	100%	75%
Standard X—Practice Guidelines	100%	100%
Standard XI—Health Information Systems	100%	100%
Standard XII—Quality Assessment and Performance Improvement	100%	100%
Standard XIII—Grievance and Appeal System	77%	

*Bold text indicates standards that HSAG reviewed during CY 2022–2023.
**Grey shading indicates standards for which no comparison results are available.

Table A-11 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 2022–2023.

Table A-11—Summary of HBN Scores for the CY 2022–2023 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Credentialing	100	93	93	0	7	100%
Recredentialing	90	80	79	1	10	99%
Totals	**190**	**173**	**172**	**1**	**17**	**99%**

* 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, Timeliness, and Access]**

Five out of the seven standards reviewed during CY 2022–2023 met 100 percent compliance and HSAG identified no required actions. Additionally, **HBN** scored 100 percent compliance on the credentialing record reviews. **[Quality, Timeliness, and Access]**

HBN achieved full compliance for the Enrollment and Disenrollment standard, demonstrating that the MCE had policies and procedures that included all required provisions. Members were accepted into the health plan without restriction, and 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 that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. **[Timeliness and Access]**

HBN achieved full compliance in the Practice Guidelines standard, demonstrating that 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 that the MCE had processes in place for how information is captured, processed, 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 that 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, Timeliness, and Access]**

HBN received a score of 94 percent for the Provider Selection and Program Integrity standard and 99 percent on the recredentialing record reviews. During the sample record review, HSAG determined that one file exceeded the recredentialing time period of 36 months. **HBN** must follow its documented process for recredentialing within 36 months, which complies with the requirements of the contract. **[Quality, Timeliness, and Access]**

HBN received a score of 75 percent for the Subcontractual Relationships and Delegation standard. Upon HSAG's review, **HBN**'s delegation agreement with their pharmacy benefit manager (PBM), did not include all provisions required by federal regulations and **HBN**'s contract with DHHS. **[Quality]**

HBN must ensure that all contracts and written 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 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.

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

Table A-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

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

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.
Response
Describe initiatives implemented based on recommendations: **HBN** reviewed all findings and recommendations from HSAG. **HBN** implemented required and recommended changes, including updating policies, member and provider materials, and conducting staff training on updates to processes.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): The **HBN** Utilization Management team and Grievance and Appeals team monitor response times and completeness of records and have seen improvements in compliance.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: **HBN**'s Compliance team, in collaboration with cross-functional team leads, monitors updates to State and federal requirements and contractual modifications to ensure updates to policies and processes are implemented timely, member and provider materials are updated, and associate training is completed, if indicated.
Recommendations
HBN received a score of 83 percent for 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.
Response
Describe initiatives implemented based on recommendations: **HBN** reviewed the Advance Directives policy as well as member materials referencing advance directives and made revisions as recommended to ensure ongoing compliance with contractual requirements and clarity for members.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** developed and implemented a state-specific Advance Directives training for associates to ensure up-to-date and consistent information is provided.
Recommendations
HBN received a score of 77 percent for 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, and 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, and 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).
Response
Describe initiatives implemented based on recommendations: **HBN** reviewed the member handbook, other member and provider materials, and internal policies included in this standard. **HBN** made revisions to ensure updated regulation language and current processes are reflected and that information provided to members and providers is clear, concise, and comprehensive.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **HBN** completes ongoing monitoring to ensure vendors continue to meet established contractual, State and federal guidelines.
Identify any barriers to implementing initiatives: None
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue oversight of vendors to ensure required service levels continue to be met and will continue to monitor any changes to State and federal regulations to ensure any updates are not only reflected in **HBN** processes, but materials as well, and members and/or providers are notified if indicated.
Recommendations
HBN received a score of 86 percent for the Adequate Capacity and Availability of Services standard. **HBN** must define its Americans with Disabilities 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.
Response
Describe initiatives implemented based on recommendations: **HBN** adopted Elevance Health's corporate ADA Compliance for Participating Providers Policy which outlines expectations for provider's compliance with ADA requirements and processes **HBN** utilizes to monitor and track. **HBN** completes an annual Cultural Needs Assessment with the goal of identifying members' cultural, ethnic, racial, or linguistic barriers; develop materials and processes to mitigate those barriers; and ensure resources and provider education to address these barriers are provided. This report was provided in a follow-up submission to HSAG. **HBN**'s network manager reviewed policies related to availability and accessibility; revisions were made to expand standards and update definitions. Additionally, scripting for appointment availability surveys was updated to include the expanded standards.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** provider experience representatives will continue to monitor providers' ADA compliance when site visits/on-site meetings occur, as well discussing with providers during virtual meetings, etc.

Recommendations
HBN received a score of 84 percent for the Coverage and Authorization of Services standard. **HBN** must ensure that urgent/expedited requests for continued inpatient stays 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.
Response
Describe initiatives implemented based on recommendations: HBN's UM team added a team lead position that focuses on providing staff training and assisting UM managers monitor turnaround time of authorization request processing to ensure ongoing compliance. Refresher training was completed with UM staff. System updates were made to **HBN**'s UM platform that enhanced associate's ability to prioritize and ensure time frames are met. **Heathy Blue** updated its notification process so members receive a notification when an authorization denial is overturned.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HBN's UM team improved overall compliance audit scores from 94.35 percent in 2021 to 99.17 percent year to date (YTD) 2022.
Identify any barriers to implementing initiatives: None
Identify strategy for continued improvement or overcoming identified barriers: HBN's UM managers monitor turnaround times daily and also track results over time to address any barriers and ensure associates continue to meet State and federal requirements.
Recommendations
HBN received a score of 94 percent for the Provider Selection and Program Integrity standard. **HBN** must develop administrative and/or management procedures to detect and prevent fraud, waste, and abuse (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.
Response
Describe initiatives implemented based on recommendations: HBN maintains a Compliance Work Plan and SIU Antifraud Plan that both address **HBN**'s processes for preventing and detecting FWA. These documents, in addition **HBN**'s FWA associate training decks were provided in a subsequent submission to HSAG to demonstrate compliance. **HBN** reviewed and updated the provider handbook section on record retention to ensure alignment with existing **HBN** policy and provider agreement documents.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: HBN will monitor for updates to federal and State regulations to ensure associate trainings, policies and processes remain up-to-date and compliant.

Recommendations
HBN received a score of 77 percent for 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.
Response
Describe initiatives implemented based on recommendations: **HBN**'s Grievance and Appeals teams reviewed identified letter templates, handbooks, and policies and made revisions to ensure all materials and processes reflect updated State and Federal guidance. Additionally, **HBN** Grievance and Appeals mangers completed training with their respective teams to review documentation changes and ensure associates are utilizing correct processes consistently.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **HBN**'s Grievance and Appeals managers monitor response and resolution turnaround times to ensure they are being met in compliance with State and federal requirements. **HBN** has processes in place to monitor and address any deficiencies. Internal audits completed by the Grievance manager and lead show grievances are no longer being closed prematurely and are fully investigated and resolved.
Identify any barriers to implementing initiatives: None.

Identify strategy for continued improvement or overcoming identified barriers: **HBN**'s Grievance and Appeal teams continuously review their processes and monitor response times to ensure they remain in compliance with State and federal requirements. Ongoing internal monthly audits will continue to ensure associates are resolving grievances and appeal in accordance with State and federal guidelines.

Validation of Network Adequacy

Results

Network Capacity Analysis

Table A-13 displays the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for **HBN**. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYN were limited to female members 15 years of age and older.

Table A-13—Statewide Population for Eligible Members for HBN

Member Population	HBN
Children 18 Years and Younger	64,892
Females 15 Years and Older	37,596
All Members*	115,170

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

Table A-14 displays the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for **HBN**.

Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table A-14—Statewide Network Capacity Analysis Results for HBN*

Provider Category**	HBN	
	Providers	Ratio***
PCPs	5,017	1:23
High Volume Specialists:**		
− Cardiologists	278	1:415

Provider Category**	HBN	
	Providers	Ratio***
– Neurologists	241	1:478
– OB/GYNs	396	1:95
– Oncologists/Hematologists	121	1:952
– Orthopedics	337	1:342
Pharmacies	114	1:1,011
Behavioral Health Inpatient and Residential Service Providers	4	1:28,793
Behavioral Health Outpatient Assessment and Treatment Providers	3,078	1:38
Hospitals	163	1:707

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** Providers include those serving all ages as well as those serving age-specific segments of the population. Member-to-provider ratios could be much higher for child members to pediatric providers, for example, than for adult members to providers that primarily serve adults

*** In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older.

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

Geographic Network Distribution Analysis

Nebraska has set geographic access standards for most providers in terms of distance in miles, apart from Hospitals for which the standard is defined in terms of time in minutes.

Table A-15 displays the percentage of **HBN**'s members with access to their provider network according to the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable (i.e., for PCPs, Pharmacies, and Behavioral Health Providers). Results were reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results were reported statewide (i.e. for High Volume Specialists and Hospitals).

Table A-15—Percentage of Members With Required Access to Care by Provider Category and Urbanicity for HBN*

Provider Category	Urbanicity**	HBN
		Percentage of Members With Required Access
PCPs	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%

Provider Category	Urbanicity**	HBN
		Percentage of Members With Required Access
High Volume Specialists* **		
− Cardiologists	Statewide	>99.9%
− Neurologists	Statewide	>99.9%
− OB/GYNs	Statewide	>99.9%
− Oncologists/Hematologists	Statewide	99.5%
− Orthopedics	Statewide	100.0%
Pharmacies	Urban (90%)	89.8%
	Rural (70%)	48.4%
	Frontier (70%)	80.9%
Behavioral Health Inpatient and Residential Service Providers	Urban	98.0%
	Rural	97.0%
	Frontier	87.6%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	100.0%
	Rural	100.0%
	Frontier	99.5%
Hospitals	Statewide	99.3%

* Red cells indicate that minimum geographic access standards were not met by **HBN** for a specific provider category in a specific urbanicity.

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

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

The State of Nebraska is divided into six Behavioral Health Regions, each comprising several counties which collaborate in planning service implementation for behavioral health in their area. For that reason, access to behavioral health services were also examined by region, using the same distance standards. Table A-16 displays the percentage of **HBN**'s members with the access to care required by contract standards for behavioral health categories by region.

Table A-16—Percentage of Members With Required Access to Behavioral Health Services by Provider Category and Region for HBN*

Region	HBN
	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	57.8%
Region 3	100.0%
Region 4	>99.9%
Region 5	100.0%
Region 6	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	99.8%
Region 3	100.0%
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%

*Red cells indicate that minimum geographic access standards were not met by **HBN** for a specific provider category in a specific Behavioral Health Region.

Table A-17 identifies the counties where the minimum geographic access standards were not met by **HBN** in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table A-17—Counties Not Meeting Standards for HBN by Urbanicity and Behavioral Health Region

Provider Category	Counties Not Meeting Standard*
PCPs	
Urban	Lincoln
PCPs, Pediatric	
Urban	Lincoln
High Volume Specialists**	
Cardiologists	Cherry
Neurologists	Boyd
OB/GYNs	Cherry
Oncologists/Hematologists	Cherry, Grant, Sheridan

Provider Category	Counties Not Meeting Standard*
High Volume Specialists, Pediatric†**	
Cardiologists, Pediatric	Boyd, Brown, Cherry, Holt, Keya Paha, Richardson, Rock
Neurologists, Pediatric	Adams, Antelope, Banner, Boone, Box Butte, Boyd, Brown, Buffalo, Cherry, Cheyenne, Dawes, Deuel, Dundy, Franklin, Furnas, Garden, Garfield, Grant, Greeley, Hall, Harlan, Holt, Howard, Kearney, Keya Paha, Kimball, Knox, Loup, Madison, Merrick, Morrill, Nance, Nuckolls, Phelps, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Valley, Webster, Wheeler
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, York
Orthopedics, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, Wheeler
Pharmacies	
Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Custer, Dawes, Fillmore, Furnas, Hamilton, Harlan, Holt, Jefferson, Johnson, Kearney, Keith, Nance, Nuckolls, Pawnee, Phelps, Richardson, Stanton, Webster, York
Frontier	Arthur, Blaine, Chase, Deuel, Grant, Hooker, Sheridan, Thomas
Behavioral Health Inpatient and Residential Service Providers	
Urban	Lincoln
Rural	Cherry, Red Willow
Frontier	Dundy, Frontier, Hayes, Hitchcock, Hooker, McPherson
Region 2	Dundy, Frontier, Hayes, Hitchcock, Hooker, Lincoln, McPherson, Red Willow
Region 4	Cherry
Behavioral Health Outpatient Assessment and Treatment Providers	
Frontier	Dundy

Provider Category	Counties Not Meeting Standard*
Region 2	Dundy
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Adams, Buffalo, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Polk, Red Willow, Richardson, Saline, Thayer, Valley, Webster, York
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Region 1	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Region 2	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
Region 3	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
Region 4	Antelope, Boone, Boyd, Brown, Cedar, Cherry, Holt, Keya Paha, Knox, Madison, Nance, Platte, Rock
Region 5	Butler, Fillmore, Gage, Jefferson, Johnson, Nemaha, Pawnee, Polk, Richardson, Saline, Thayer, York
Region 6	Dodge
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Box Butte, Buffalo, Cherry, Custer, Dawes, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler

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

Strengths

HBN achieved 100 percent compliance with six of nine network access standards that were presented by urbanicity, one of six network access standards that applied statewide, and nine of 12 behavioral health access standards presented by Behavioral Health Region. **[Access]**

HBN achieved at least 98 percent compliance with all of the remaining access standards, except for Behavioral Health Inpatient and Residential Service Providers in rural and frontier areas. **HBN** met the standard for Pharmacies in frontier areas. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

HBN's greatest opportunities for improvement are to strengthen its networks of pharmacies available in rural counties and Behavioral Health Inpatient and Residential Service Providers in frontier areas. **[Quality, Timeliness, and Access]**

In addition, **HBN** could significantly improve access to pediatric specialists across all provider types and regions. **[Quality, Timelines, and Access]**

For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Quality, Timeliness, and Access]**

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

Table A-18 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table A-18—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: **HBN**'s Network and Provider Experience teams reviewed the deficiencies noted by HSAG and have developed interventions to address and resolve them.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **HBN**'s interventions, implemented as a result of HSAG's recommendations, have not been in place long enough at this point to show improvement. **HBN** continues to monitor and track provider data coming in to show efficacy of the interventions.
Identify any barriers to implementing initiatives: Provider data entered into **HBN**'s system are vetted against the State Provider File to ensure information is consistent with the provider's enrollment with the State, so it is imperative that the providers update the State Provider file and inform **HBN** when changes are made.
Identify strategy for continued improvement or overcoming identified barriers: **HBN**'s Network and Provider Experience teams will continue to identify ways to improve the accuracy and integrity of provider data and work with providers to improve consistency in provider data.

Recommendations
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. • 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. • 12.9 percent of provider service location addresses were associated with County Federal Information Processing Series (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.
Response
Describe initiatives implemented based on recommendations: In an effort to address a deficiency in collecting data related to non-English languages spoken by **HBN** providers, the following actions were implemented. All these efforts will assist in improving the accuracy of information included in the provider directory to meet the cultural needs of members and eliminate any potential barriers of care due to language barriers. • **HBN**'s Digital Provider Enrollment (DPE) platform will require new providers enrolling to become a participating provider to list any non-English languages they speak. • An update has been made to the roster template used by agencies to add new providers (credentialing not required) to include a column to include languages spoken, other than English. • The Behavioral Health Area of Expertise Profile document that is being implemented includes a section for behavioral health providers to indicate services provided in languages other than English • **HBN** added a question related to languages other than English spoken by the provider, to **HBN**'s Assessment of Physician Director Survey, which is an annual survey that **HBN** conducts to ensure accurate information is collected from providers so that the directory reflects appropriately. • Provider education will take place through newsletters and provider meetings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): As the DPE platform is new to **HBN**, an increase in the number of providers reporting non-English languages spoken has not yet been noted, but ongoing monitoring continues.
Identify any barriers to implementing initiatives: Based on current data, the majority of network providers do not speak a language other than English, but the interventions outlined above will provide additional information for members related to providers that do speak a language other than English. Regarding multiple provider locations and geocodes, provider information entered into **HBN**'s provider data system is vetted against the State Provider File to ensure information is consistent with the provider's enrollment with the State so it is imperative the providers update the State Provider file and **HBN** when changes are made.
Identify strategy for continued improvement or overcoming identified barriers: **HBN** will continue to educate providers to complete demographic updates with the State, as well as with **HBN** to ensure consistency, and will complete audits to identify inconsistencies or data quality issues when needed.

Validation of Performance Improvement Projects

Results

NTC submitted one PIP, *Plan All-Cause Readmissions*, focused on improving performance in the total observed 30-day readmission rate for the HEDIS *Plan All-Cause Readmissions (PCR)* measure, for the 2022–2023 validation cycle. The PIP received an overall *Not Met* validation status for the initial submission. **NTC** sought technical assistance to address the initial validation feedback and resubmitted the PIP. After resubmission, the PIP received a final overall *Met* validation status. Table B-1 summarizes **NTC**'s PIP validation scores.

Table B-1—2022–2023 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
Plan All-Cause Readmissions (PCR)	Initial Submission	58%	56%	*Not Met*
	Resubmission	90%	100%	*Met*

Overall, 90 percent of all applicable evaluation elements received a score of *Met*. Table B-2 presents baseline and Remeasurement 1 performance indicator data for **NTC**'s *Plan All-Cause Readmissions* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

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

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

N–Numerator D–Denominator

For the baseline measurement period, **NTC** reported that 11.01 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of

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

Interventions

For the *Plan All-Cause Readmissions (PCR)* PIP, **NTC** used brainstorming and a fishbone diagram to identify the following barriers and interventions to improve performance indicator outcomes.

Table B-3 displays the barriers to improvement that **NTC** identified and the interventions **NTC** initiated to address those barriers.

Table B-3—Barriers and Interventions for NTC's *Plan All-Cause Readmissions* PIP

Barriers	Interventions
Lacking support for members post-discharge	Outreach members to complete a transition of care (TOC) assessment form, which is used to identify post-discharge member needs. The outreach includes discharge education review, invitation to enroll in case management, assisting with follow-up appointment scheduling, and offering transportation assistance.
Existing TOC process does not identify all members in need of post-discharge outreach and support	TOC assessment workflow update and staff education to ensure all eligible members are identified and outreached.
Lack of structured member referral process from utilization management (UM) program to case management (CM) program	UM to CM referral process update to include a readmission score greater than 50 as a trigger to initiate the member referral process.

Strengths

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

- **NTC** followed a methodologically sound PIP design for the baseline and Remeasurement 1 periods that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **NTC** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **NTC** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

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

- **NTC** reported indicator results that demonstrated a decline in performance from baseline to Remeasurement 1. **[Quality]**

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

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

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

Table B-4 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table B-4—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: **NTC** moved the PCR PIP from an O/E Ratio to a percentage. With this shift, the data were easier to utilize within the Quick Start Guide for Statistical Testing. To ensure accuracy, **NTC** requested and received a technical assistance meeting with HSAG prior to resubmission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **NTC** was able to identify via the Fisher's exact test that two-tailed p value equaled 0.0625 and therefore was considered not statistically significant from baseline PCR rate to remeasurement year one.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: **NTC** will continue to utilize the statistical tool to analyze performance and significance.

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: From this recommendation, **NTC** looked further into its current intervention. Moving through the PDSA cycle by studying the PCR data results along with further analyzing the TOC process, it was decided to pivot. TOC intervention. Further analysis of the PIP's population was completed along with a new Barrier, Opportunity, Improvement (BOI) process. In turn, The TOC intervention was retired and replaced with an initiative that would focus on targeting the primary diagnosis falling into the PCR readmission group: behavioral health.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): NTC has implemented monthly meetings with key stakeholders to review current rates and interventions, and move through the PDSA cycle.
Identify any barriers to implementing initiatives: Knowledge deficit: Updated staff education is scheduled for Q4 2022, which includes reviewing the PDSA cycle and the use of the A3 work process. All quality departmental staff will receive the training along with key stakeholders across the health plan.
Identify strategy for continued improvement or overcoming identified barriers: Annual training will be available for staff on PDSA, 5 Why's and the A3 problem-solving method.
Recommendations
Revisit causal/barrier analyses at least annually to ensure the identified barriers and opportunities for improvement are still applicable.
Response
Describe initiatives implemented based on recommendations: The next monthly PIP meeting is to be held on September 16, 2022. During this meeting, the group will revisit causal/barrier analyses to ensure the identified barriers are still present.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Moving through the PDSA cycle by studying the PCR data results along with further analyzing the TOC process, it was decided to pivot the TOC intervention. Further analysis of the PIP's population was completed along with a new BOI process. In turn, the TOC intervention was retired and replaced with an initiative that would focus on targeting the primary diagnosis falling into the PCR readmission group: behavioral health.
Identify any barriers to implementing initiatives: Not all key players have an understanding of the PDSA cycle or BOI process.
Identify strategy for continued improvement or overcoming identified barriers: Training to be completed Q4 2022; added to the annual PIP work plan to ensure causal/barrier analyses are completed annually, at minimum.
Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.

Response
Describe initiatives implemented based on recommendations: Following the above process of analyzing causes/barriers, the PIP team will utilize a key driver diagram to determine and prioritize barriers and process gaps/weaknesses.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): During the monthly PIP meeting, the current PCR rate is reviewed. There are no significant improvements in the measure to report as of yet.
Identify any barriers to implementing initiatives: The success rate of reaching this behavioral health population is low.
Identify strategy for continued improvement or overcoming identified barriers: A new position has been created in September 2022 for a dedicated TOC staff member. This individual will reach out to the facility/member prior to discharge to begin relationship building and post-hospitalization planning. All behavioral health discharges will be filtered through this staff, unless the member is already active in case management with another staff within the health plan.

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 2021 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-5—Summary of Compliance With IS Standards for NTC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 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 steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	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.
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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
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. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**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.
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.	**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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
• 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 validated data resulting from the DAV program met reporting requirements.	
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.
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-certified measure 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-6 reflect all final reported rates in **NTC**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for reporting. It is possible that **NTC** may have received an "*NA*" status for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table B-6—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***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table B-7—NTC's HEDIS Measures Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
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% ★★	69.34% ★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	56.34% ★★	55.96% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	60.00% ★★★	57.18% ★★	R
CIS: Childhood Immunization Status—Combination 3	69.10% ★★★★	70.07% ★★★★★	R
CIS: Childhood Immunization Status—Combination 7	—	61.56% ★★★★★	R
CIS: Childhood Immunization Status—Combination 10	49.64% ★★★★★	47.45% ★★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	74.94% ★★	78.10% ★★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	—	33.33% ★★★	R
LSC: Lead Screening in Children	69.97% ★★★	68.94% ★★★★	R
BCS: Breast Cancer Screening	47.94% ★★	54.48% ★★★★	R
CCS: Cervical Cancer Screening	63.16% ★★★★	58.39% ★★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	26.96% ★	28.02% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	42.01% ★	44.46% ★	R
CHL: Chlamydia Screening in Women—Total	32.17% ★	34.22% ★	R
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	71.04% ★	70.31% ★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	63.24% ★★★	63.08% ★★★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65 and Older	NA	NA	R
CWP: Appropriate Testing for Pharyngitis—Total	69.77% ★★★	68.15% ★★★	R
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	16.67% ★	22.41% ★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	75.82% ★★★★★	72.20% ★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	89.54% ★★★★★	87.89% ★★★★	R
AMR: Asthma Medication Ratio—Ages 5 to 11	81.51% ★★★★	83.71% ★★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
AMR: Asthma Medication Ratio—Ages 12 to 18	73.47% ★★★★	72.69% ★★★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	65.84% ★★★★★	62.29% ★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	63.51% ★★★★★	59.26% ★★★★	R
AMR: Asthma Medication Ratio—Total	73.71% ★★★★★	71.99% ★★★★★	R
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure—Controlling High Blood Pressure	63.75% ★★★★★	61.31% ★★★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	76.67% ★★★	R
Effectiveness of Care: Diabetes			
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	85.40% ★★★★	89.78% ★★★★★	R
*CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	44.28% ★★★	39.90% ★★★★	R
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	47.20% ★★★★	51.82% ★★★★	R
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	57.18% ★★★★	57.66% ★★★★★	R
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	63.02% ★★★★	66.91% ★★★★	R
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	52.05% ★★	64.57% ★★★★	R
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	39.41% ★★★	47.12% ★★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	46.33% ★★★★	40.68% ★★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	61.05% ★★★★	48.39% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	48.11% ★★★	46.12% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	71.64% ★★★	68.98% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up— Ages 18 to 64	35.24% ★★★★	29.22% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	55.87% ★★★★	47.10% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	40.52% ★★★★	34.49% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.45% ★★★★	53.92% ★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness —7-Day Follow-Up—Total	48.36% ★★★★	43.33% ★★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness —30-Day Follow-Up—Total	65.37% ★★★★★	61.39% ★★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—Total	28.31% ★★★	25.08% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	45.18% ★★★	42.52% ★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total	8.21% ★★★	16.20% ★★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —30-Day Follow-Up—Total	13.37% ★★★	22.12% ★★★★	R
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.29% ★★★★★	80.96% ★★★★	R
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	70.20% ★★★★	65.48% ★★★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.11% ★★★★★	64.82% ★★★★	R
Effectiveness of Care: Overuse/Appropriateness			
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.70% ★★★	0.64% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	87.51% ★★	89.58% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years	76.08% ★★★	79.40% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older	NA	NA	R
URI: Appropriate Treatment for Upper Respiratory Infection—Total	85.98% ★★	87.75% ★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
LBP: Use of Imaging Studies for Low Back Pain — Use of Imaging Studies for Low Back Pain	76.94% ★★★★	73.55% ★★★	R
*HDO: Use of Opioids at High Dosage**	5.59% ★★★	2.39% ★★★★	R
Access/Availability of Care			
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17	34.07% ★	33.05% ★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17	17.22% ★★★★	15.48% ★★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 18 and Older	38.40% ★★	44.50% ★★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 18 and Older	9.25% ★★	13.17% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total	37.64% ★★	43.62% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD—Total—Total	10.64% ★★★	13.35% ★★★	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	76.89% ★★	77.86% ★★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	73.24% ★★★	76.16% ★★★	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% ★★★★	65.23% ★★★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	68.47% ★★★	67.85% ★★★★	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^*	0.00 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^*	0.03 NC	0.05 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^*	0.00 NC	0.02 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^*	0.01 NC	0.00 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^*	0.11 NC	0.20 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^*	0.21 NC	0.18 NC	R
*FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^*	0.62 NC	0.56 NC	R
*FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^*	0.36 NC	0.35 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^*	0.07 NC	0.09 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^*	0.21 NC	0.22 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—15–44 Years—Female^*	0.16 NC	0.20 NC	R
*FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^*	0.18 NC	0.10 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^*	0.05 NC	0.02 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^*	0.01 NC	0.01 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^*	0.03 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^*	0.38 NC	0.44 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^*	0.73 NC	0.80 NC	R
*FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^*	0.79 NC	0.76 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^*	0.38 NC	0.34 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^*	0.84 NC	0.76 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^*	0.21 NC	0.19 NC	R
*FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^*	0.82 NC	0.90 NC	R
*FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^*	0.08 NC	0.02 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^	0.43 NC	0.20 NC	R
FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^	0.08 NC	0.08 NC	R
FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^	0.58 NC	0.43 NC	R
AMB: Ambulatory Care (Per 1,000 Member Months)—Emergency Department Visits—Total^,*	40.37 ★★★★	52.21 ★★	R
AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^	314.72 NC	360.81 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^	6.90 NC	6.84 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total All Ages	4.59 NC	5.08 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total All Ages^	5.73 NC	3.97 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total All Ages	2.53 NC	2.66 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total All Ages^	1.16 NC	1.49 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total All Ages	10.21 NC	9.59 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total All Ages^	2.45 NC	2.83 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total All Ages	4.68 NC	4.87 NC	R
Risk Adjusted Utilization			
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	11.66% NC	13.08% NC	R
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	10.86% NC	10.90% NC	R
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	1.07 ★★★	1.20 ★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
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 2021 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 or the rate was not displayed in the previous year.
* For this indicator, a lower rate indicates better performance.
HEDIS MY 2021 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-8—NTC's CMS Core Set Measure Rates

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
Adult Core Measures		
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 18 to 64**	—	21.31%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 65+**	—	16.25%
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	33.20%	37.93%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—18 to 64**	—	3.53%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—65+**	—	1.41%
*PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,000 Member Months)**	2.72	2.82
Child Core Measures		
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^*	31.32	77.47
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^*	25.36	35.97
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—10 to 19^*	24.15	29.93
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Total^*	—	52.21
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 1 Year	—	24.22%

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 2 Years	—	31.23%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 3 Years	—	29.72%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	28.26%

The MCO's CMS Adult and Child Core measures were not required to be audited; however, the MCO's LO conducted an audit of these measures.
^ Rate is reported per 1,000 beneficiary months rather than a percentage.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*, *Lead Screening in Children*, *Breast Cancer Screening*, and *Cervical Cancer Screening* measure indicators were a strength for **NTC**. For the *Childhood Immunization Status* measure indicators, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 75th percentile benchmark, while the *Lead Screening in Children*, *Breast Cancer Screening*, and *Cervical Can Screening* measures ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. The *Childhood Immunization Status—Combination 3*, *Combination 7*, 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 *Lead Cancer Screening* rate demonstrates children under 2 years of age are adequately receiving a lead blood test to ensure they are maintaining limited exposure to lead. 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] 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]**

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: Nov 1, 2022.

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 July 30. Available at: https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html. Accessed on: Nov 1, 2022.

Effectiveness of Care: Respiratory Conditions Domain

All *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation* measure indicators were a strength for **NTC**. For these measure indicators, **NTC**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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 rates, **NTC** providers are appropriately prescribing 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]**

Finally, the *Appropriate Testing for Pharyngitis—Ages 18 to 64* measure indicator was also a strength for **NTC**. For this measure indicator, **NTC**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. This rate indicates that **NTC** providers are appropriately testing to warrant antibiotic treatment for members in this indicator with a diagnosis of pharyngitis. **[Quality]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for **NTC**. For this measure, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th 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 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 **NTC**. For these measure indicators, **NTC**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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]**

[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: Nov 1, 2022.

[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: Nov 1, 2022.

[B-6] Centers for Disease Control and Prevention (CDC). 2020. "National diabetes statistics report, 2020." Atlanta, GA: U.S. Department of Health and Human Services. Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html. Accessed on: Nov 1, 2022.

Effectiveness of Care: Behavioral Health Domain

For the following measure indicators, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark:

- *Antidepressant Medications Management—Effective Acute Phase Treatment Phase* and *Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—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*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Based on these rates, **NTC** 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). In addition, **NTC** providers were able to follow up with children after being diagnosed with ADHD during the initiation phase of their treatment to ensure their initial medication levels were managed appropriately to help manage attention and impulsive disorders. Also, **NTC** providers were appropriately managing care for patients discharged after an ED visit for mental health issues and AOD abuse or dependence, as they are vulnerable after release. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions,[B-7,B-8,B-9] while timely follow-up care for individuals with AOD who were seen in the ED is associated with a reduction in substance use, future ED use, and hospital admissions.[B-10,B-11,B-12] In addition, because members with SMI who use antipsychotics are at increased risk of cardiovascular

[B-7] Griswold, K.S., Zayas, L.E., Pastore, P.A., Smith, S.J., Wagner, C.M., Servoss, T.J. (2018) Primary Care After Psychiatric Crisis: A Qualitative Analysis. *Annals of Family Medicine*, *6(1), 38-43*. doi:10.1370/afm.760.

[B-8] Kyriacou, D.N., Handel, D., Stein, A.C., Nelson, R.R. (2005). Brief Report: Factors Affecting Outpatient Follow-up Compliance of Emergency Department Patients. *Journal of General Internal Medicine, 20(10), 938-942*. doi:10.1111/j.1525-1497.2005.0216_1.x.

[B-9] Bruffaerts, R., Sabbe, M., Demyffenaere, K. (2005). Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *General Hospital Psychiatry, 27, 269-74*.

[B-10] Kunz, F.M., French, M.T., Bazargan-Hejazi, S. (2004). Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. *Journal of Studies on Alcohol and Drugs, 65, 363-370*.

[B-11] Mancuso, D., Nordlund, D.J., Felver, B. (2004). Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division.

[B-12] Parthasarathy, S., Weisner, C., Hu, T.W., Moore, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. *Journal of Studies on Alcohol and Drugs, 62, 89-97*.

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-13] **[Quality, Timeliness, and Access]**

Effectiveness of Care: Overuse/Appropriateness Domain

The *Use of Opioids at High Dosage* measure was a strength for **NTC**. For this measure, **NTC** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. This rate demonstrates that **NTC** 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.[B-14] Of those, 40 percent involved prescription opioids.[B-19] Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose.[B-15,B-16,B-17]**[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* and *Initiation of AOD Treatment—Total—Ages 18 and Older* measure indicators were a strength for **NTC**. For this measure indicator, **NTC**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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, while ages 18 and older initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. **[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 for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators were a strength for **NTC**. For these measure indicators, **NTC**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile

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[B-13] 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: Nov 1, 2022.

[B-14] 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: Nov 1, 2022.

[B-15] 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.

[B-16] 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.

[B-17] 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.

benchmark. This indicates children within the first 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]**

Risk Adjusted Utilization Domain

HSAG did not identify any strengths when conducting the PMV for **NTC** within the Risk Adjusted Utilization domain.

Measures Reported Using ECDS Domain

HSAG did not identify any strengths when conducting the PMV for **NTC** within the Measures Reported Using ECDS domain.

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*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* measure indicators were a weakness for **NTC**. For these measure indicators, **NTC**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-18] HSAG continued to recommend that **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 continuation of the COVID-19 PHE, 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 *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were also a weakness for **NTC**. For these measure indicators, **NTC**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including 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-19] HSAG continued to recommend that **NTC** providers follow up annually with sexually active members through any type of communication such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low

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[B-18] Centers for Disease Control and Prevention (CDC). 2013 "Adolescents and School Health: Childhood Obesity Facts." Available at: https://www.cdc.gov/healthyschools/obesity/index.htm. Accessed on: Nov 1, 2022; and American Heart Association. 2013. "Overweight in Children."

[B-19] 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.

rate in members accessing these services is identified as related to the continuing COVID-19 PHE, 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**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. HSAG continued to recommend that **NTC** conduct a root cause analysis for the *Appropriate Testing for Pharyngitis—Ages 3 to 17* 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-20] If the low rate in members accessing these services is identified as related to the continuation of the COVID-19 PHE, 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: Cardiovascular Conditions Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the Effectiveness of Care: Cardiovascular Conditions domain.

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the Effectiveness of Care: Diabetes domain.

Effectiveness of Care: Behavioral Health Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the Effectiveness of Care: Behavioral Health domain.

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**. For these measure indicators, **NTC**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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 continued to recommend that **NTC** conduct a root cause analysis to ensure providers

[B-20] Centers for Disease Control and Prevention. 2013. "Strep Throat: All You Need to Know." Available at: https://www.cdc.gov/groupastrep/diseases-public/strep-throat.html. Accessed on: Nov 1, 2022.

are aware of appropriate treatments that can reduce the danger of antibiotic-resistant bacteria.[B-21] In addition, HSAG continued to recommend 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* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care.[B-22] HSAG continued to recommend that **NTC** work with its providers to ensure they are reaching members with identified 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 also a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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.[A-23] 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-24] HSAG continued to recommend that **NTC** work with its providers on best practices for providing ongoing prenatal care. This is especially important during the continuation of the COVID-19 PHE, as pregnant and recently pregnant women are at a higher risk for severe illness from COVID-19 than nonpregnant women.[B-25] **[Quality, Timeliness, and Access]**

[B-21] 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: Nov 1, 2022.

[B-22] National Library of Medicine. Patient Characteristics Associates with Treatment Initiation and Engagement Among Individuals Diagnosed with Alcohol and Other Drug Use in the Emergency Department and Primary Care Settings. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6669120/. Accessed on: Nov 1, 2022.

[B-23] CDC Review to Action. (2018). Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Retrieved from: http://reviewtoaction.org/Report_from_Nine_MMRCs.

[B-24] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

[B-25] 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: Nov 1, 2022.

Utilization Domain

The *Ambulatory Care—Emergency Department Visits—Total* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked at or below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark, suggesting higher utilization of services. HSAG recommended **NTC** conduct a root cause analysis of why this rate changed significantly from last year and determine what actions should take place in order to improve the rate.

Risk Adjusted Utilization Domain

The *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator was a weakness for **NTC**. For this measure indicator, **NTC**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th 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.[B-26] 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]**

Measures Reported Using ECDS Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **NTC** within the Measures Reported Using ECDS domain.

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

Table B-9 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table B-9—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for 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**. 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. HSAG recommended that DHHS work with **NTC** and its providers to strategize the best way to use every office

[B-26] 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.

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 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services.

- 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.
- 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 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 for women receiving these services is identified to be related to the COVID-19 PHE, DHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for improved access to these services.
- 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. 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 PHE, 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.

Response

Describe initiatives implemented based on recommendations:

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total* and *Counseling for Nutrition—Total*: Analysis of HEDIS hybrid chart submission has been conducted with gaps identified in completion and documentation. Supplemental Data Source (SDS) file data were also analyzed down to the individual provider sources to ensure that the data for BMI were being pulled in to meet the HEDIS BMI specifications. Individual discussions with source providers have been completed to ensure their SDS files were corrected for *WCC-BMI*, showing the percentage. **NTC**'s HEDIS team met with VBC contacts to ensure chart submissions through the provider portal were correct for elements within the documentation. Provider education was developed with sample documentation. Presentation/discussion for *WCC* was led by **NTC**'s chief medical officer to all of the VBCs in the months of June/July/August 2022. Further education was distributed through the July 2022 eNews containing an article on completing *WCC* at WCV or sports physical appointments. Lastly, the HEDIS Quick Reference Guide was posted to **NTC**'s website on June 8, 2022.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap): Immunization data through NESIIS were submitted and ingested into the HEDIS platform Q4 2021. Data analysis was complete for IMA Q1 2022. No provider trends were identified in the analysis. Findings showed members for IMA were missing one HPV

dose by the 13th birthday. Per **NTC**'s HEDIS platform, approximately 1,700 were noncompliant in 2021. Using Nebraska State Immunization Information System (NESIIS) data: of those 1,700, almost 720 had only received one HPV dose by their 13th birthday: 42 percent of all noncompliant; 151/720 received their first dose after their 13th birthday; 316/720 received their 2nd dose after their 13th birthday. On average, the second dose was 12 months after the first dose. Provider education and discussions specific to this information was shared by the chief medical officer (CMO), in the June, July, and August 2022 VBC meetings. Additionally, **NTC** continues a stratified outreach plan to members through the Pfizer Immunization platform, member emails, and Proactive Outreach Manager (POM) calls.

Breast Cancer Screening: A barrier analysis and roundtable idea discussion for root cause analysis has been conducted at the Preventative HEDIS work group in Q2 of 2022. Analysis of the BCS data showed ZIP Code 68111 as a disparity zone. Twice in 2022, **NTC** partnered with Nebraska Health Systems/Methodist Hospital to place the mammogram coach at a location within that targeted zone (May 2022/August 2022). The location was in collaboration with Charles Drew, a local federally qualified health center (FQHC). After completing outreach to members in 68111, **NTC** reached out to members in surrounding ZIP Codes to fill additional available appointments. A follow-up call was made to members prior to their scheduled mammography date as an appointment reminder and to address any transportation barriers. Unfortunately, these appointments were not kept, despite making calls from the site on the same day to further confirm and members stating they were going to be there.

Targeted POMs and email messaging continue to be sent to members that have yet to complete a screening in CY2022. Additionally, **NTC** continues to work with VBC groups, sharing reports and offering provider incentive for BCS.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: *CHL* performance was discussed at the VBC meeting in Q3 2022. Children's Hospital, one of the VBCs, has identified a performance improvement project on *CHL*.

NTC has a robust email and POM campaign to target women for their different health needs depending upon their age:

- POM 2022: Well Woman (*CHL CCS BCS*) bi-annually
- Email plan 2022: Chlamydia screening (*CHL*) women, one month before 16th-20th birthday; chlamydia and cervical cancer screening *(CHL/CCS*) women, one month before 21st–24th birthday; additionally, **NTC**'s Health Resources website page includes a chlamydia PDF resource.

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

WCC BMI MY 2021 (55.96) noted a 12.41 percent increase from MY 2018 (56.93) and a 4.95 increase from previous MY 2020 (64.39). MY 2022 9.2.22 QSIxl run 34.89 compared against prior year MY 2020 run (32.35) shows a +2.54.

WCC Counseling for Nutrition noted no change from 2018 (55.96) and a slight decrease of -0.38 from MY 2020 (56.34) to 2021 (55.96). MY 2022 9.2.22 QSIxl run 17.31 compared against prior year MY 2020 run (18.73) shows a -1.42.

WCC Counseling Physical Activity MY 2021 (57.18) noted an increase of 14.01 from MY 2018 (43.07) and a -2.82 from MY 2020 (60.0) to 2021. MY 2022 9.2.22 QSIxl run 24.31 compared against prior year MY 2020 run (25.78) shows a -1.47.

IMA combo 2 MY 2021 (33.33) noted a 10.22 increase from 2018 (23.11) and a 7.54 increase from previous MY 2020 (25.79). MY 2022 9.2.22 QSIxl run 24.64 compared against prior year MY 2020 run (24.05) shows a +2.59.

BCS MY 2021 (54.48) saw a 0.36 increase from 2019 (54.12) and a 6.54 increase from MY 2020 (47.94) from 2021. MY 2022 9.2.22 QSIxl run 51.24 compared against prior year MY 2020 run (45.81) shows a +5.43.

CHL MY 2021 (34.22) noted a decrease of -1.81 from MY 2018 (36.03) to 2021 but a 2.05 increase from MY 2020 (32.17) to 2021. MY 2022 9.2.22 QSIxl run 28.15 compared against prior year MY 2020 run (24.99) shows a +3.16.

Identify any barriers to implementing initiatives:

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total* and *Counseling for Nutrition—Total*: No barrier noted with implementation

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap): No barrier noted

Breast Cancer Screening: Members not showing for mobile mammography appointments indicates this intervention was unsuccessful; no trend identified as of yet as to why these appointments were not kept despite confirmation calls.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: Not all members have a phone, email, or access to the Internet, which can be a barrier to outreach.

Identify strategy for continued improvement or overcoming identified barriers:

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total* and *Counseling for Nutrition—Total*: Continued monitoring of SDS file submission. **NTC** has identified one source provider needing correction. Continued evaluation of provider chart submissions to identify trends/opportunities, with potential outreach to provider sources for education. Implemented penny claim process for capturing Current Procedural Terminology II (CPTII) codes, evaluating *WCC* impact. 2023 MyHealth Pays WCV reward.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap): Discussion of barriers with provider groups at provider committees/meetings. Continued analysis of data. Outreach is proactive in the timeline to ensure **NTC** are reaching member prior to the immunization dates. 2023 MyHealth Pays HPV reward.

Breast Cancer Screening: Explore: partnership with radiology centers for outreach/making appointments for **NTC**'s members or partner with Cancer Society for outreach. Continue to work with VBC/providers to capture ongoing historical data that may lead to exemptions with new and existing members. 2023 MyHealth Pays BCS reward.

Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*: Continued various modalities of outreach; Women's Health Fair partnerships; SDoH Assessments. Continued provider messaging.

Recommendations for 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. If the low rate in members accessing these services is identified as related to the COVID-19 PHE, 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.
- 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 plan that may protect against worsening symptoms and decrease the number of exacerbations. HSAG recommended that DHHS ensure **NTC** and its providers are aware of spirometry testing to help create a treatment plan for members with COPD.

Response
Describe initiatives implemented based on recommendations: *CWP* The following was identified in the Attest audit 2022: The increased use of telehealth visits during the COVID-19 PHE spiked in medical health clinics, potentially a cause for decreased testing for pharyngitis. The use of personal protective barriers (masks, social distancing, etc.) was potentially the reason for an overall decrease in respiratory illness such as influenza and pharyngitis, thus decreasing the overall denominator. Members during a COVID spike avoided going into the office setting, and therefore hands-on testing was not completed. National trends overall showed a decrease in testing for pharyngitis due to COVID surges. **NTC** will implement data analysis and an appropriate intervention for 2023. *Appropriate Testing for Pharyngitis* is included in the Q4 2022 Provider Newsletter (pending State approval). *SPR* The TruCare documentation platform for **NTC**'s care management team includes a template for COPD. This care plan includes speaking with the member's provider in regard to breathing exercises and lung therapy/testing. Care plans are shared with the member's PCP upon enrollment in active case management. Specific provider education on *SPR* will be created and launched in 2023, assuming State approval.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *CWP* noted a 1.66 percentage point increase in MY 2021 (68.15) compared to 2018 (66.49), and a decrease by -1.62 from previous year MY 2020 (69.77). MY 2022 9.2.22 QSIxl run 67.53 compared against prior year MY 2020 run (68.13) shows a -0.6. *SPR* MY 2021 (22.41) noted a -7.26 from baseline of MY 2019 (29.67) of this measure and an increase by 5.74 from MY 2020 (16.67). MY 2022 9.2.22 QSIxl run 27.63 compared against prior year MY 2020 run (20.45) shows a +7.18.
Identify any barriers to implementing initiatives: *CWP* and *SPR*: Data analysis needed.
Identify strategy for continued improvement or overcoming identified barriers: *CWP*: Analysis of data to look at the type of clinic visit, coinciding with prescription date; looking for trends with telehealth. *CWP* and *SPR*: Create provider messaging in relation to findings within data analysis as well as basic measure education to be implemented in 2023.
Recommendations 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 and 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 changes 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. 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.

Response
Describe initiatives implemented based on recommendations: <u>*AMM*</u> Monthly Email and POM to members with a new prescription for antidepressant. Quarterly Email to members on antidepressant(s). AMM provider training will be uploaded to the **NTC** provider website once MLTC reviews and approves.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *AMM* continuation phase MY 2021 (47.12) noted an increase of 11.03 from MY 2018 (36.09) and an increase of 7.71 from previous MY 2020 (39.41). MY2022 9.2.22 QSIxl run 44.29 compared against prior year MY 2020 run (41.76) shows a +2.53. *AMM* Acute phase MY 2021 (64.57) noted an increase of 15.83 from MY 2018 (48.74) and an increase from previous MY2020 (52.08) by 12.52. MY2022 9.2.22 QSIxl run 62.41 compared against prior year MY 2020 run (62.50) shows a +0.09.
Identify any barriers to implementing initiatives: No barrier noted to implementation of email workflow; however, not all members have an email or phone. Provider training is pending State approval and will be implemented once approved.
Identify strategy for continued improvement or overcoming identified barriers: Looking at other avenues to outreach to members with new Rx for an antidepressant; will bring to table for discussion with **NTC**'s pharmacy department along with area pharmacists for BOI Q4 2022.
Recommendations for 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. 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.
Response
Describe initiatives implemented based on recommendations: <u>*URI*</u> These measure data were further analyzed during the Attest Audit. The quality department will be attending the provider committee meetings/townhalls and be added as an ongoing agenda item to solicit feedback on various HEDIS measures beginning Q4 2022 and moving into 2023. The *URI* measure will be added for discussion on BOI. An article reviewing *URI* is included in the Q4 2022 Provider Newsletter (currently at the State for approval process).
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *URI* MY 2021(87.74) noted a 1.56 increase from MY 2018 (86.18) and a 1.76 increase from previous MY 2020 (85.98). MY 2022 9.2.22 QSIxl run 88.18 compared against prior year MY 2020 run (87.70) shows a +0.48.
Identify any barriers to implementing initiatives: Currently, no identified barriers.

Identify strategy for continued improvement or overcoming identified barriers: Data analysis of *URI* and soliciting provider insight to Barrier, Opportunity, Improvement (BOI) with URI.

Recommendations for 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—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. HSAG recommended that **NTC** work with its providers to ensure they are reaching members with identified 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. 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. 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. 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.
- *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. HSAG recommended that **NTC** work with its providers to ensure they are reaching members with identified 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.
- 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. 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. 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.

Response

Describe initiatives implemented based on recommendations:

IET-i/IET-e

Provider education and discussion for *IET* is being led by the CMO at all VBC meetings in the months of September, October, and November 2022.

Provider education via **NTC**'s eNews distribution is planned for October 2022 (pending State approval). Q4 2022 Provider Newsletter contains information on best practices (pending State approval). *IET* provider training to be uploaded to **NTC** provider website upon State approval of material. *PPC-t* **NTC** has educated and incentivized providers on early notification of pregnancy forms that identify a pregnant member for early outreach and support by **NTC**'s Start Smart for Baby (SSFB®) program and case management. This program adds another layer of education and support. For instance, SDoH are discussed with the member to ensure there are no barriers, such as transportation, which need to be removed for the member to attend appointments. **NTC** is currently performing a PIP to increase the total number of delivered members with a completed NOP by 3 percent in 2022 as compared to 2021. Penny claims process for CPT II codes submission has been implemented to help identify the first prenatal appointment due to bundled billing in NE for collaborative care between **NTCs** SSFB and the OB office. Furthermore, the **NTC** provider and member website is robust with resources on caring for expecting mothers. **NTC** has representation on Nebraska Perinatal Quality Collaborative, March of Dimes Impact Committee and DHHS Maternal Infant Health Collaboration, as well as other committees within the community to improve perinatal care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *IET-I* MY 2021 (43.62) noted a 4.75 increase from MY 2018 (38.87) and a 5.98 increase from MY 2020 (37.64). MY 2022 9.2.22 QSIxl run 40.01 compared against prior year MY 2020 run (42.62) shows a -2.61. *IET-e* MY 2021 (13.35) noted a 1.56 increase from MY 2018 (11.79) and a 2.71 increase from MY 2020 (10.64. MY 2022 9.2.22 QSIxl run 11.99 compared against prior year MY 2020 run (11.88) shows a -0.11. *PPC-t* MY 2021 (77.86) noted a 4.41 increase from MY 2018 (73.45) and a 0.97 increase from MY 2020 (76.89). MY 2022 9.2.22 QSIxl run 48.79 compared against prior year MY 2020 run (37.75) shows a +11,04.
Identify any barriers to implementing initiatives: *IET*: Due to not receiving data/information on a new diagnosis in an automated or consistent way, outreaching to members has been a barrier to get them into a program within the measure's timeline of 14 days post diagnosis. Therefore, provider education has been the strategy—No barriers identified to implementing this education. Barrier of lack of open programs/availability has been identified. *PPC-t*: The biggest barrier to *PPC* is that Nebraska is a bundled billing state. Therefore, we do not receive a claim alerting us that a member is pregnant. We rely heavily on member or provider notification as well as claims being entered that may be related to pregnancy (i.e., Vaginal Ultrasound; Pregnancy Test). Recently, we initiated a penny claim process for the first OB visit as another way to identify a pregnant member.
Identify strategy for continued improvement or overcoming identified barriers: *IET*: Roundtable with providers/EDs to discuss how the health plan can be alerted of a new diagnosis and where we can assist in getting the member in for treatment. Three Quality staff members attended the September 2022 Provider Advisory Committee. A handful of HEDIS measures were brought for roundtable discussion of insight, ideas, and barriers; Quality will continue this agenda item within this committee in Q4 2022 and into 2023 for feedback. PPC-t: Discussion is at the State level to unbundle OB billing.

Recommendations for 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 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. 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.
Response
Describe initiatives implemented based on recommendations: *PCR* **NTC**'s quality data analyst and risk adjustment manager are working together to bring in diagnosis for membership. Cync Health diagnosis/data will help with risk adjustment and therefore, some of the members that fall into the observed may be taken out due to falling into the expected category of the *PCR* measure.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): *IET-I* MY 2021 (43.62) noted a 4.75 increase from MY 2018 (38.87) and a 5.98 increase from MY 2020 (37.64). *IET-e* MY 2021 (13.35) noted a 1.56 increase from MY 2018 (11.79) and a 2.71 increase from MY 2020 (10.64). *PPC-t* MY 2021(77.86) noted a 4.41 increase from MY 2018 (73.45) and a 0.97 increase from MY 2020 (76.89). Improvement as a result of initiative pending updated data integration—First load: January 2023
Identify any barriers to implementing initiatives: With Cync Health, **NTC** could have access to all diagnoses. Quality analyst is looking into where these will be stored for the data to be housed/utilized.
Identify strategy for continued improvement or overcoming identified barriers: Provider education will be provided via a Q4 2022 or Q1 2023 eNews.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table B-10—Compliance With Regulations—Trended Performance for NTC

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**NTC Results**	
Standard I—Enrollment and Disenrollment	100%	100%
Standard II—Member Rights and Confidentiality	67%	
Standard III—Member Information	86%	

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**NTC Results**	
Standard IV—Emergency and Poststabilization Services	100%	100%
Standard V—Adequate Capacity and Availability of Services	100%	
Standard VI—Coordination and Continuity of Care	100%	
Standard VII—Coverage and Authorization of Services	89%	
Standard VIII—Provider Selection and Program Integrity	100%	100%
Standard IX—Subcontractual Relationships and Delegation	75%	100%
Standard X—Practice Guidelines	100%	100%
Standard XI—Health Information Systems	100%	100%
Standard XII—Quality Assessment and Performance Improvement	100%	100%
Standard XIII—Grievance and Appeal System	58%	

*Bold text indicates standards that HSAG reviewed during CY 2022–2023.

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

Table B-11 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 2022–2023.

Table B-11—Summary of NTC Scores for the CY 2022–2023 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**166**	**166**	**0**	**24**	**100%**

* 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, dashboards, diagrams, manuals, agreements, meeting minutes, and sample communications. Documents illustrated a thorough and comprehensive approach to complying with regulations and contract requirements. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the seven standards reviewed during CY 2022–2023 and HSAG identified no required actions. Additionally, **NTC** scored 100 percent compliance on the credentialing and recredentialing record reviews. **[Quality, Timeliness, and Access]**

NTC achieved full compliance in the Enrollment and Disenrollment standard, demonstrating that the MCE had policies and procedures that included all required provisions. Members were accepted into the health plan without restriction, and 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 that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. **[Timeliness and Access]**

NTC achieved full compliance in the Provider Selection and Program Integrity standard, demonstrating that **NTC** had appropriate provider monitoring and processes to monitor, identify, plan, and mitigate FWA. **NTC** 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 that the MCE had a process in place to review and update clinical practice guidelines regularly. The guidelines routed 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 that the MCE had processes in place for how information is captured, processed, 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 that the MCE had maintained a well-developed, thorough, and continuous QAPI program. **NTC**'s program outlined activities such as PIPs, 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

HSAG found **NTC**'s policy, Non-Discrimination in Contracting Practices, included provisions for prohibiting provider discrimination that referenced 42 CFR §438.12(a)(1)–(2); 438.214(c). Additionally, **NTC** provided a Nondiscriminatory Credentialing and Recredentialing policy and procedure with state-specific attachments. However, after reviewing the policy and attachment, HSAG determined that the documentation did not mention Nebraska-specific details. To avoid confusion and ensure consistency with other states' documentation, HSAG recommended that **NTC** include the provisions prohibiting

provider discrimination found in 42 CFR §438.12(a)(1)–(2); 438.214(c) by adding them to the Nebraska-specific attachment of the Nondiscrimination Credentialing and Recredentialing policy. **[Quality, Timeliness, and Access]**

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

Table B-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

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

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.
Response
Describe initiatives implemented based on recommendations: Initial and ongoing review of findings and recommendations are conducted by the Compliance team through a number of activities, including but not limited to, determination of responsible parties, facilitation of departmental discussions, providing recommendations of process improvements, monitoring status, archiving evidence, conducting internal audits, ensuring policy language is updated, and further leveraging support from other sources as needed. Through utilization of a tracking log and the organization's records management system (Archer), Compliance is able to assign tasks, monitor efforts, and assist with responses to said findings and recommendations. As an additional layer of initiatives, the compliance officer leverages support of senior leadership on a weekly basis for report-outs of process improvement efforts.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Compliance has successfully conducted internal audits, meeting a passing score of samples reviewed on a quarterly basis for Provider Directory updates and member letters meeting a 6.9-grade reading level, as well as an annual audit to ensure local policies are reviewed and updated. All events entered into the Archer system from the 2021 EQR findings and recommendations have been finalized and closed. The fully compliant findings from the 2022 EQR also speak to noted performance improvements since the 2021 EQR.
Identify any barriers to implementing initiatives: No concerns to note.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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).
Response
Describe initiatives implemented based on recommendations: The local health plan policy NE.MBRS.02-Member Rights and Responsibilities has been updated with recommendations previously identified by HSAG.
Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The identified recommendations were previously included in the published Rights and Responsibilities for members. This language added to the policy did not change any procedures or member experience based on existing publication of Rights and Responsibilities. There is no substantive performance improvement.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: NTC has updated the website information sheet and its website to include a notice that the member is informed of information available in paper format without charge upon request and is provided within five business days. Ongoing efforts are in process for updates to the provider directories to include website URLs for providers, as well as collecting provider URLs as new providers are enrolled in the network. Updates to the grievance and State fair hearing sections of the member handbook to include messaging that assistance is available for completing grievances and State fair hearing forms have been completed. **NTC** has taken steps to ensure its process for sending termination letters aligns with the timelines outlined within its policy and has participated in quarterly compliance audits to validate compliance with this initiative.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The provider directory continues to be updated with additions of provider URLs added through ongoing efforts to identify and update absent URLs. Quarterly compliance audits have been conducted successfully with departmental discussions resulting in passing audit scores and increased notification of member moves when impacted by provider terminations.
Identify any barriers to implementing initiatives: The existing provider network has not historically provided URLs, so the data collection is taking place as changes are captured and/or during new provider enrollment, as well as the **NTC** data team actively identifying absent URLs and making updates in real time.
Identify strategy for continued improvement or overcoming identified barriers: Roster templates posted publicly and utilized for provider enrollment were updated to capture URLs and reports are being run on a routine basis to identify providers with absent URLs.
Recommendations
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).
Response
Describe initiatives implemented based on recommendations: **NTC** (**NTC**) has developed an updated claims Service Verification/NABD member explanation of benefits (EOB) template for NE Medicaid that will be incorporated into a standard member notification related to NABDs that occur at the claim adjudication level. These templates are currently in process with **NTC**'s IT team for implementation into production scope and funding. Once **NTC** completes the internal approval process, the templates will be sent to MLTC for review and approval. Upon MLTC approval, the templates will be loaded to support automated distribution upon experience of an NABD claims event. Implementation is targeted for the end of Q4 2022 into Q1 2023. In December of 2021, the UM training department conducted training for all UM staff who develop member letters to ensure a 6.9-grade reading level is met. The process developed includes the use of Flesch Kincaid within Microsoft to verify the grade level of the letter content being sent to members. Once the letter is produced, the letter is then sent to the staff member's people leader for review. 100 percent of all denial letters are reviewed within the UM department, by department leadership. Additional audits are performed based on a random sampling for additional oversight of reading grade level.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Review and approval of 100 percent denial letters has successfully been conducted within the UM department with the opportunity for ongoing feedback and education as needed, based upon random sample audit results.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: None identified.
Recommendations
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.

Response
Describe initiatives implemented based on recommendations: Based on the recommendations, an NE Subcontractor Medicaid Attachment was created and added to all **NTC** (**NTC**) subcontractor agreements. A tracking log was utilized to manage the status of adding this attachment to all **NTC** subcontracts. The inclusion of this attachment has been incorporated into the contracting process for all new **NTC** subcontractors going forward.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All **NTC** subcontractor agreements have successfully been updated with an executed attachment that includes the required language and specific regulatory requirements.
Identify any barriers to implementing initiatives: Due to the number of subcontractors, obtaining the signed attachment back in a timely manner from all subcontractors was an ongoing and time-consuming effort.
Identify strategy for continued improvement or overcoming identified barriers: The inclusion of the attachment has been added to the list of due diligence tasks for onboarding new **NTC** subcontractors. This includes the filing of the attachment to MLTC, as part of the subcontractor approval process.
Recommendations
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 Office of Civil Rights (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 have 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, "**NTC** 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.
Response
Describe initiatives implemented based on recommendations: **NTC** (**NTC**) has fully revised the grievance and appeal policy based on HSAG recommendations including, but not limited to, enabling acceptance of oral only grievances and expedited to standard language. The revised policy has been approved by MLTC and is active. The grievance and appeal extension letter(s) has been revised in accordance with recommendations with the revision approved by MLTC. **NTC** implemented an updated readability review process to ensure all letters meet a 6.9-grade level on the Flesch-Kincaid scale; this has been adopted into standard practice. All grievance and appeal letters have been reviewed with any updates needed being completed with MLTC review and approval pertaining to grievance rights inclusion. The grievance and appeal content of the provider manual has been updated with MLTC review and approval. The expedited to standard letter has been updated to include grievance rights with MLTC review and approval. The first call resolution letter notification process has been developed as an SOP with handling instructions for Member Services and grievance and appeal staff. The first call resolution template letter has been approved by MLTC and **NTC** is currently working with **NTC**'s IT solutions product team to have the letter loaded into production to support an efficient/automated processing and distribution. The current estimated time of arrival for the letter load to production and implementation of the first call resolution notification follow up letters is expected to be the end of Q4 2022.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): All documentation and process enhancements have supported compliance with HSAG findings to ensure content is in line with requirements.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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 and 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").
Response
Describe initiatives implemented based on recommendations: **NTC** (**NTC**) has fully revised the grievance and appeal policy based on HSAG recommendations including, but not limited to, enabling acceptance of oral only grievances and expedited to standard language. The revised policy has been approved by MLTC. **NTC** has also developed separate and distinct grievance and appeal forms in line with HSAG recommendations which have been reviewed and approved by MLTC and currently in production.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): All documentation and process enhancements have supported compliance with HSAG findings to ensure content is in line with requirements.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.

Validation of Network Adequacy

Results

Network Capacity Analysis

Table B-13 displays the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for **NTC**. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYN were limited to female members 15 years of age and older.

Table B-13—Statewide Population of Eligible Members for NTC

Member Population	NTC
Children 18 Years and Younger	63,862
Females 15 Years and Older	44,616
All Members*	125,042

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

Table B-14 displays the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for **NTC**.

Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table B-14—Statewide Network Capacity Analysis Results for NTC*

Provider Category**	NTC	
	Providers	Ratio***
PCPs	3,012	1:42
High Volume Specialists:**		
− Cardiologists	336	1:373
− Neurologists	252	1:497
− OB/GYNs	337	1:133
− Oncologists/Hematologists	123	1:1,017
− Orthopedics	345	1:363
Pharmacies	241	1:519
Behavioral Health Inpatient and Residential Service Providers	5	1:25,009
Behavioral Health Outpatient Assessment and Treatment Providers	3,065	1:41
Hospitals	108	1:1,158

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** Providers include those serving all ages as well as those serving age-specific segments of the population. Member-to-provider ratios could be much higher for child members to pediatric providers, for example, than for adult members to providers that primarily serve adults

*** In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older.

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

Geographic Network Distribution Analysis

Nebraska has set geographic access standards for most providers in terms of distance in miles, apart from Hospitals for which the standard is defined in terms of time in minutes.

Table B-15 displays the percentage of **NTC**'s members with access to their provider network according to the geographic access standards established by DHHS. Findings have been stratified by provider category and urbanicity, where applicable. Results were reported by urbanicity if geographic access standards for the provider category differed according to urbanicity; otherwise, results were reported statewide.

Table B-15—Percentage of Members With Required Access to Care by Provider Category and Urbanicity for NTC*

Provider Category	Urbanicity**	NTC
		Percentage of Members With Required Access
PCPs	Urban	100.0%
	Rural	100.0%
	Frontier	100.0%
High Volume Specialists* **		
− Cardiologists	Statewide	>99.9%
− Neurologists	Statewide	100.0%
− OB/GYNs	Statewide	100.0%
− Oncologists/Hematologists	Statewide	99.5%
− Orthopedics	Statewide	100.0%
Pharmacies	Urban (90%)	95.0%
	Rural (70%)	62.7%
	Frontier (70%)	97.4%
Behavioral Health Inpatient and Residential Service Providers	Urban	100.0%
	Rural	100.0%
	Frontier	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	>99.9%
	Rural	99.9%
	Frontier	97.6%

Provider Category	Urbanicity**	NTC
		Percentage of Members With Required Access
Hospitals	Statewide	97.1%

* Red cells indicate that minimum geographic access standards were not met by **NTC** for a specific provider category in a specific urbanicity.

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

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

The State of Nebraska is divided into six Behavioral Health Regions, each comprising several counties which collaborate in planning service implementation for behavioral health in their area. For that reason, access to behavioral health services were also examined by region, using the same distance standards. Table B-16 displays the percentage of **NTC**'s members with the access to care required by contract standards for behavioral health categories by region.

Table B-16—Percentage of Members With Required Access to Behavioral Health Services by Provider Category and Region for NTC*

Region	NTC
	Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	100.0%
Region 3	100.0%
Region 4	100.0%
Region 5	100.0%
Region 6	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	98.2%
Region 3	100.0%
Region 4	99.8%
Region 5	100.0%
Region 6	100.0%

*Red cells indicate that minimum geographic access standards were not met by **NTC** for a specific provider category in a specific Behavioral Health Region.

Table B-17 identifies the counties where the minimum geographic access standards were not met by **NTC** in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table B-17—Counties Not Meeting Standards for NTC by Urbanicity and Behavioral Health Region

Provider Category	Counties Not Meeting Standard*
PCPs, Pediatric	
Urban	Lincoln
High Volume Specialists†**	
Cardiologists	Cherry
Oncologists/Hematologists	Cherry, Grant, Sheridan
High Volume Specialists, Pediatric†**	
Cardiologists, Pediatric	Brown, Cherry, Loup
Neurologists, Pediatric	Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Chase, Cherry, Cheyenne, Custer, Dawes, Deuel, Dundy, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Red Willow, Rock, Scotts Bluff, Sheridan, Sioux, Thomas
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thomas, Valley, Wayne, Webster, Wheeler
Orthopedics, Pediatric	Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Cedar, Chase, Cherry, Cheyenne, Custer, Dawes, Deuel, Dixon, Dundy, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Morrill, Perkins, Pierce, Platte, Red Willow, Rock, Scotts Bluff, Sheridan, Sioux, Stanton, Thomas, Wayne, Wheeler
Pharmacies	
Urban	Buffalo, Dawson, Dodge, Gage, Lincoln, Scotts Bluff
Rural	Cedar, Cheyenne, Clay, Custer, Dawes, Furnas, Hamilton, Harlan, Holt, Kearney, Keith, Knox, Nance, Nemaha, Otoe, Pawnee, Phelps, Polk, Richardson, Wayne, York
Frontier	Grant, Hooker, Thomas
Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln
Rural	Cherry
Frontier	Dundy, Grant, Hooker, Thomas
Region 2	Dundy, Grant, Hooker, Lincoln, Thomas
Region 4	Cherry

Provider Category	Counties Not Meeting Standard*
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Adams, Buffalo, Dawson, Dodge, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Colfax, Cuming, Custer, Dawes, Furnas, Harlan, Holt, Keith, Knox, Nemaha, Nuckolls, Pierce, Red Willow, Richardson, Stanton, Thayer, Wayne
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas
Region 1	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Region 2	Arthur, Chase, Dawson, Dundy, Frontier, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
Region 3	Adams, Blaine, Buffalo, Custer, Furnas, Harlan, Loup, Nuckolls
Region 4	Antelope, Boone, Boyd, Brown, Cedar, Cherry, Colfax, Cuming, Holt, Keya Paha, Knox, Madison, Pierce, Platte, Rock, Stanton, Wayne
Region 5	Butler, Nemaha, Richardson, Thayer
Region 6	Dodge
Hospitals**	
Hospitals	Adams, Arthur, Banner, Blaine, Box Butte, Brown, Buffalo, Cherry, Cheyenne, Clay, Colfax, Custer, Dawes, Dawson, Dixon, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Grant, Greeley, Harlan, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, McPherson, Nuckolls, Saunders, Sheridan, Sherman, Sioux, Thayer, Thomas, Valley, Wheeler

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

Strengths

NTC achieved compliance with 11 network access standards by urbanicity and 10 behavioral health access standards by Behavioral Health Region. **[Access]**

NTC achieved at least 98 percent compliance with two network access standards by urbanicity and two behavioral health access standards by Behavioral Health Region. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

NTC’s greatest opportunity for improvement is to strengthen its network of pharmacies available to members in rural counties. **[Quality, Timeliness, and Access]**

In addition, **NTC** could significantly improve access to pediatric specialists across all provider types and regions. **[Quality, Timeliness, and Access]**

For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Quality, Timeliness, and Access]**

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

Table B-18 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table B-18—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: **NTC** has reviewed recommendations provided by HSAG and provided a detailed response that is described under the second recommendation.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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. • 17.4 percent of **NTC**'s servicing or billing providers contained no unique Provider ID, although 100 percent contained valid NPIs. • 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. • 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. • 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.

Response
Describe initiatives implemented based on recommendations: The 2021 file used for this review included records from **NTC**'s vendors, including the vision vendor. A total of 98.6 percent of the providers without a business name have a vision specialty. Based on the 2022 EQR, vision records from **NTC**'s vendor are not included in the review and this should not be an issue in the future. After removing ancillary types (Ambulance, durable medical equipment [DME], etc.) as well as out-of-state providers, we identified 1.1 percent of providers that do not have a degree listed. We are working to identify the appropriate provider degree from rosters as they are received. We do not have a concern with County FIPS codes outside of Nebraska as **NTC** has purposefully contracted with out-of-state providers for specialty needs, as well as instances where cross-border facilities are needed to fill access requirements (Cheyenne, WY; Rapid City, SD; Yankton, SD; Sioux City, IA; etc.). The Nebraska Medicaid provider file dated 12/31/2021 identified 22.64 percent of the service locations not within the state of Nebraska. At this time, **NTC** is unable to replicate the finding with providers associated with more than 10 physical locations and has found no evidence of a data quality issue. When data are analyzed at the NPI level, there are a total of 41,077 NPIs. Of those NPIs, 19,479 have one location, 36,341 NPIs have between one and nine locations, and 4,736 have 10 or more locations, accounting for 11.5 percent with more than one location, including hospitals, FQHCs, clinics, pharmacies, and traveling specialists.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Nonparticipating provider claims do not include certain data elements, including the provider degree.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.

Validation of Performance Improvement Projects

Results

UHCCP submitted one PIP, *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission*, focused on improving performance in the total observed 30-day readmission rate for the *HEDIS Plan All-Cause Readmissions (PCR)* measure, for the 2022–2023 validation cycle. The PIP received an overall *Met* validation status for the initial submission and the resubmission. Table C-1 summarizes **UHCCP**'s PIP validation scores.

Table C-1—2022–2023 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
Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission	Initial Submission	81%	100%	*Met*
	Resubmission	95%	100%	*Met*

Overall, 95 percent of all applicable evaluation elements received a score of *Met*. Table C-2 presents baseline and Remeasurement 1 performance indicator data for **UHCCP**'s *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP, which was used to objectively assess for improvement. The performance indicator was an inverse indicator, where a lower percentage demonstrates better performance.

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

Performance Indicator	Baseline (01/01/2019 to 12/31/2019)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Sustained Improvement
Total observed 30-day readmission rate for members 18–64 years of age who have had an acute inpatient or observation stay for any diagnosis during the measurement year.	N: 133	11.76%	N: 149	10.44%	*Not Assessed*
	D: 1,131		D: 1,427		

N–Numerator D–Denominator

For the baseline measurement period, **UHCCP** reported that 11.76 percent of inpatient discharges for members 18 to 64 years of age were followed by an unplanned acute readmission within 30 days of

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

Interventions

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

Table C-3 displays the barriers to improvement that **UHCCP** identified and the interventions **UHCCP** initiated to address those barriers.

Table C-3—Barriers and Interventions for UHCCP's *Reducing Avoidable Hospital Readmissions After an Acute Inpatient Hospital Admission* PIP

Barriers	Interventions
Member medication noncompliance	Targeted outreach to reconcile medications within 14 days of an acute inpatient discharge for members with a primary behavioral health or medical diagnosis.
Lack of member participation in care management services to support management of behavioral health and/or physical medical conditions	Targeted outreach for members with a primary behavioral health or medical diagnosis prior to an acute inpatient stay to provide education on care management services and engage members in care management services.
Insufficient or inaccurate member contact information	Actively seek out and update member contact information as part of targeted member outreach.

Strengths

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

- **UHCCP** followed a methodologically sound PIP design for the baseline and Remeasurement 1 periods that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- **UHCCP** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality]**
- **UHCCP** conducted barrier analyses to identify and prioritize barriers to improvement, and initiated interventions to address priority barriers. **[Quality]**
- **UHCCP** reported performance indicator results that demonstrated an improvement in the overall 30-day readmission rate from baseline to Remeasurement 1. **[Quality]**

Summary Assessment of Opportunities for Improvement and Recommendations

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

- Although **UHCCP**'s reported indicator results demonstrated an improvement in performance from baseline to Remeasurement 1, the improvement was not statistically significant. **[Quality]**

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

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

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

Table C-4 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table C-4—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: The health plan completes quarterly and annual evaluations of the data to measure the effectiveness of each intervention. The health plan HEDIS team targeted outreach to members in three interventions. 1. Case managers will outreach to members with a primary behavioral health or medical diagnosis after an acute inpatient stay to reconcile medications within 14 calendar days of discharge. 2. Case managers will outreach to members with a primary behavioral health or medical diagnosis prior to discharge from an acute inpatient stay to educate and engage member in care management services.

3. Case managers will outreach members with a primary behavioral health or medical diagnosis after an acute inpatient stay within 30 days of discharge and attempt to locate a valid phone number to successfully reach members and update member contact information.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2021, the health plan saw a slight decrease in the overall HEDIS measurement rate from 11.76 percent to 10.44 percent. While there was not a statistically significant change noted in the *PCR* HEDIS measurement year over year based on the Chi-square model, it did show an overall downward trend. The Health Plan decided to continue with interventions one through three. In 2021, intervention number one demonstrated 1,733 unique members were successfully outreached and completed medication reconciliation and transition of care assessment within 14 calendar days of discharge. Intervention number two demonstrated that 731 members were successfully outreached prior to discharge from an acute inpatient stay and members were educated on their available care management benefit. Intervention number three demonstrated that 50 unique members were successfully outreached post discharge who had previously been unable to reach due to invalid contact information, presenting an opportunity to assist members who were previously unable to be reached.
Identify any barriers to implementing initiatives: Barriers identified were: a. Difficulty in obtaining and maintaining valid contact information for members b. Inpatient telephonic outreaches are difficult as members may be unavailable due to medical testing or other medical services such as physical therapy, speech therapy, or occupational therapy. c. Inpatient behavioral health units/facilities either limiting or prohibiting member phone interactions
Identify strategy for continued improvement or overcoming identified barriers: The health plan PIP workgroup will continue to perform PDSA cycles to re-evaluate the effectiveness of the identified interventions. The health plan will also work to develop relationships with hospital/facility discharge planning teams, review all data sources for current member telephonic contact information, and perform face-to-face visits with members if appropriate (pandemic conditions).
Recommendations
Revisit causal/barrier analyses at least annually to ensure the identified barriers and opportunities for improvement are still applicable.
Response
Describe initiatives implemented based on recommendations: An annual review of the causal/barrier analyses was completed. The PIP workgroup verifies the identified barriers and opportunities for improvement and reviews any newly identified barriers that may present themselves. The PIP case managers were retrained on the interventions. This included retraining on the Transitions of Care Assessment, medication reconciliation process, and documenting member contact information in the member charting system. Staff were further instructed to assist members with any identified barriers, such as SDoH needs, and make referrals for ongoing case management as needed. A review of the member call scripts was also conducted.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HEDIS *PCR* rate changed from 11.76 percent to 10.44 percent.
Identify any barriers to implementing initiatives: Quarterly data analysis identified stronger efforts were needed to reach members within 30 days of discharge in attempts to locate a valid phone number to successfully outreach member. Additional barriers also include difficulty with inpatient outreaches being

considerably more difficult as members are difficult to reach due to medical testing, inpatient routine care, and inpatient behavioral health units/facilities either limiting or prohibiting member interaction.
Identify strategy for continued improvement or overcoming identified barriers: The health plan will continue with the three identified interventions. The health plan case managers will engage with facility discharge planners.
Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
Response
Describe initiatives implemented based on recommendations: The health plan completed key driver diagrams and process mapping to determine barriers and process gaps. The health plan held retraining of the PIP case managers and reviewed all member call scripts.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): It is too early for the health plan to gauge the success of the retraining and member call script reviews.
Identify any barriers to implementing initiatives: None identified.
Identify strategy for continued improvement or overcoming identified barriers: The health plan will conduct staff training semi-annually.

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 2021 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-5—Summary of Compliance With IS Standards for UHCCP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 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 steps are taken to improve performance. • Contracted vendors are regularly monitored against expected performance standards.	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.
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.	**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

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
• 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.	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. • Data completeness is assessed, including steps to improve performance. • Vendor performance is monitored against expected performance standards.	**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.
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.	**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.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2021 FAR Review
• Data approved for ECDS reporting met reporting requirements. • NCQA validated data resulting from the DAV program met reporting requirements.	
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.
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-certified measure 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-6 reflect all final reported rates in **UHCCP**'s IDSS. In addition, for measures with multiple indicators, more than one rate is required for

reporting. It is possible that **UHCCP** may have received an "*NA*" status for an indicator due to a small denominator within the measure but still have received an "*R*" designation for the total population.

Table C-6—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***

*Benefits are assessed at the global level, not the service level (refer to Volume 2, General Guideline 26: Required Benefits).
**NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.
***NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.

Table C-7—UHCCP's HEDIS Measure Rates and Audit Results

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
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% ★★★	71.53% ★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	69.59% ★★★	66.42% ★★★	R
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	65.69% ★★★	65.94% ★★★	R
CIS: Childhood Immunization Status—Combination 3	78.59% ★★★★★	72.51% ★★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
CIS: Childhood Immunization Status—Combination 7	—	63.99% ★★★★★	R
CIS: Childhood Immunization Status—Combination 10	54.74% ★★★★★	49.39% ★★★★★	R
IMA: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	82.24% ★★★★	77.37% ★★★	R
IMA: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	—	34.55% ★★★	R
LSC: Lead Screening in Children	73.97% ★★★★	70.32% ★★★★	R
BCS: Breast Cancer Screening	63.77% ★★★★★	64.83% ★★★★★	R
CCS: Cervical Cancer Screening	60.83% ★★★★	57.42% ★★★	R
CHL: Chlamydia Screening in Women—Ages 16 to 20 Years	29.01% ★	28.35% ★	R
CHL: Chlamydia Screening in Women—Ages 21 to 24 Years	39.96% ★	39.71% ★	R
CHL: Chlamydia Screening in Women—Total	32.71% ★	32.69% ★	R
Effectiveness of Care: Respiratory Conditions			
CWP: Appropriate Testing for Pharyngitis—Ages 3 to 17	72.77% ★★	71.20% ★★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 18 to 64	59.87% ★★★	60.64% ★★★	R
CWP: Appropriate Testing for Pharyngitis—Ages 65 and Older	NA	NA	R
CWP: Appropriate Testing for Pharyngitis—Total	70.77% ★★★	68.10% ★★★	R
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.12% ★★★★	28.83% ★★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	67.07% ★★★	73.35% ★★★★	R
PCE: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	84.15% ★★★	86.53% ★★★★	R
AMR: Asthma Medication Ratio—Ages 5 to 11	79.72% ★★★★	78.21% ★★★★	R
AMR: Asthma Medication Ratio—Ages 12 to 18	73.62% ★★★★★	71.43% ★★★★	R
AMR: Asthma Medication Ratio—Ages 19 to 50	69.11% ★★★★★	70.88% ★★★★★	R
AMR: Asthma Medication Ratio—Ages 51 to 64	68.64% ★★★★★	64.79% ★★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
AMR: Asthma Medication Ratio—Total	74.05% ★★★★★	72.59% ★★★★★	R
Effectiveness of Care: Cardiovascular Conditions			
CBP: Controlling High Blood Pressure—Controlling High Blood Pressure	68.37% ★★★★★	71.53% ★★★★★	R
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack	NA	80.70% ★★★	R
Effectiveness of Care: Diabetes			
CDC: Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	92.21% ★★★★★	91.00% ★★★★★	R
*CDC: Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	29.68% ★★★★★	31.14% ★★★★★	R
CDC: Comprehensive Diabetes Care—HbA1c Control (<8.0%)	59.12% ★★★★★	60.10% ★★★★★	R
CDC: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.34% ★★★★★	65.94% ★★★★★	R
CDC: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	71.78% ★★★★★	76.89% ★★★★★	R
Effectiveness of Care: Behavioral Health			
AMM: Antidepressant Medication Management—Effective Acute Phase Treatment	63.93% ★★★★★	66.16% ★★★★★	R
AMM: Antidepressant Medication Management—Effective Continuation Phase Treatment	48.67% ★★★★★	52.98% ★★★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	45.64% ★★★★	39.15% ★★★	R
ADD: Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	55.30% ★★★	47.85% ★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17	56.88% ★★★★	57.83% ★★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17	78.90% ★★★★★	80.58% ★★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64	44.43% ★★★★★	41.14% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64	66.41% ★★★★★	61.84% ★★★★	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65 and Older	NA	NA	R
FUH: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	49.31% ★★★★★	45.98% ★★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
FUH: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	71.24% ★★★★★	67.21% ★★★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	45.40% ★★★★	43.78% ★★★★	R
FUM: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	66.00% ★★★★★	64.21% ★★★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—Total	13.08% ★	21.78% ★★★	R
FUI: Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—Total	30.00% ★★	42.33% ★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	8.30% ★★★	19.04% ★★★★★	R
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	12.46% ★★★	24.11% ★★★★	R
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.33% ★★★★★	82.81% ★★★★★	R
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia	68.67% ★★★★	75.21% ★★★★★	R
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	73.53% ★★★★	75.68% ★★★★	R
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia	81.13% ★★★★★	73.98% ★★★★★	R
Effectiveness of Care: Overuse/Appropriateness			
*NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.51% ★★★★	0.43% ★★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years	88.28% ★★	90.33% ★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years	78.08% ★★★	80.56% ★★★	R
URI: Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older	67.50% ★★★	NA	R
URI: Appropriate Treatment for Upper Respiratory Infection—Total	86.81% ★★★	88.53% ★★★	R
LBP: Use of Imaging Studies for Low Back Pain—Use of Imaging Studies for Low Back Pain	77.29% ★★★★	76.31% ★★★★	R
*HDO: Use of Opioids at High Dosage**	7.23% ★★★	5.19% ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
Access/Availability of Care			
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 13 to 17	33.18% ★	30.89% ★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 13 to 17	15.91% ★★★★	12.20% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Ages 18 and Older	34.66% ★	39.05% ★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Ages 18 and Older	8.23% ★★	11.07% ★★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total	34.44% ★	38.42% ★★	R
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of AOD—Total—Total	9.38% ★★★	11.16% ★★★	R
PPC: Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.05% ★★★	87.59% ★★★★	R
PPC: Prenatal and Postpartum Care—Postpartum Care	78.10% ★★★★	85.89% ★★★★★	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	61.89% ★★★★★	63.03% ★★★★★	R
W30: Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	70.35% ★★★	68.60% ★★★★	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Male^*	0.00 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Male^*	0.02 NC	0.02 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Male^*	0.10 NC	0.00 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—0–19 Years—Female^*	0.00 NC	0.01 NC	R
*FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—20–44 Years—Female^*	0.12 NC	0.19 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
FSP: Frequency of Selected Procedures—Bariatric Weight Loss Surgery—45–64 Years—Female^	0.11 NC	0.20 NC	R
FSP: Frequency of Selected Procedures—Tonsillectomy—0–9 Years—Total^	0.60 NC	0.54 NC	R
FSP: Frequency of Selected Procedures—Tonsillectomy—10–19 Years—Total^	0.29 NC	0.33 NC	R
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—15–44 Years—Female^	0.06 NC	0.06 NC	R
FSP: Frequency of Selected Procedures—Hysterectomy, Abdominal—45–64 Years—Female^	0.06 NC	0.20 NC	R
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—15–44 Years—Female^	0.21 NC	0.13 NC	R
FSP: Frequency of Selected Procedures—Hysterectomy, Vaginal—45–64 Years—Female^	0.09 NC	0.09 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—30–64 Years—Male^	0.02 NC	0.03 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—15–44 Years—Female^	0.01 NC	0.00 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Open—45–64 Years—Female^	0.09 NC	0.00 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—30–64 Years—Male^	0.35 NC	0.52 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—15–44 Years—Female^	0.81 NC	0.67 NC	R
FSP: Frequency of Selected Procedures—Cholecystectomy, Laparoscopic—45–64 Years—Female^	0.88 NC	0.85 NC	R
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Male^	0.46 NC	0.31 NC	R
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Male^	1.21 NC	0.82 NC	R
FSP: Frequency of Selected Procedures—Back Surgery—20–44 Years—Female^	0.16 NC	0.22 NC	R
FSP: Frequency of Selected Procedures—Back Surgery—45–64 Years—Female^	0.84 NC	0.96 NC	R
FSP: Frequency of Selected Procedures—Mastectomy—15–44 Years—Female^	0.08 NC	0.02 NC	R
FSP: Frequency of Selected Procedures—Mastectomy—45–64 Years—Female^	0.17 NC	0.18 NC	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
*FSP: Frequency of Selected Procedures—Lumpectomy—15–44 Years—Female^*	0.10 NC	0.10 NC	R
*FSP: Frequency of Selected Procedures—Lumpectomy—45–64 Years—Female^*	0.19 NC	0.37 NC	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Emergency Department Visits—Total^,**	37.07 ★★★★	45.79 ★★★	R
*AMB: Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total^*	326.46 NC	355.80 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Total Inpatient—Total All Ages^*	6.04 NC	5.89 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Total Inpatient—Total All Ages	5.22 NC	5.55 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Maternity—Total All Ages^*	4.38 NC	3.08 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Maternity—Total All Ages	2.36 NC	2.38 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Surgery—Total All Ages^*	1.13 NC	1.37 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Surgery—Total All Ages	10.22 NC	9.82 NC	R
*IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Discharges per 1,000 Member Months—Medicine—Total All Ages^*	2.38 NC	2.53 NC	R
IPU: Inpatient Utilization—General Hospital/Acute Care—Total—Average Length of Stay—Medicine—Total All Ages	5.89 NC	5.72 NC	R
Risk Adjusted Utilization			
*PCR: Plan All-Cause Readmissions—Observed Readmissions—Total**	8.34% NC	11.41% NC	R
*PCR: Plan All-Cause Readmissions—Expected Readmissions—Total**	11.16% NC	11.40% NC	R
*PCR: Plan All-Cause Readmissions—O/E Ratio—Total**	0.75 ★★★★★	1.00 ★★★	R

HEDIS Measures	MY 2020 HEDIS Rate	MY 2021 HEDIS Rate	MY 2021 Audit Designation
Measures Collected Using Electronic Clinical Data Systems			
BCS-E: Breast Cancer Screening	63.50% NC	64.63% NC	R

^ Rate is reported per 1,000 member months rather than a percentage.
NC indicates that a comparison to the HEDIS MY 2021 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 or the rate was not displayed in the previous year.
* For this indicator, a lower rate indicates better performance.
HEDIS MY 2021 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-8—UHCCP's CMS Core Set Measure Rates

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
Adult Core Measures		
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 18 to 64**	—	24.63%
*COB-AD: Concurrent Use of Opioids and Benzodiazepines—Ages 65+**	—	21.97%
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder—Total	51.75%	43.22%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—18 to 64**	—	4.99%
*OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer Ages—65+**	—	6.28%
*PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate (per 100,00 Member Months)**	1.73	0.97
Child Core Measures		
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Age <1^*	52.75	68.42
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits—Ages 1 to 9^*	22.27	30.76
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—10 to 19^*	20.89	24.82
*AMB-CH: Ambulatory Care: Emergency Department (ED) Visits Ages—Total^*	23.49	30.11

CMS Core Set Measures#	MY 2020 Rate	MY 2021 Rate
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 1 Year	—	26.42%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 2 Years	—	33.70%
DEV-CH: Developmental Screening in the First Three Years of Life Children—Turned 3 Years	—	32.09%
DEV-CH: Developmental Screening in the First Three Years of Life—Total	—	30.50%

The MCO's CMS Adult and Child Core measures were not required to be audited and are presented for information only.
^ Rate is reported per 1,000 beneficiary months rather than a percentage.
* For this indicator, a lower rate indicates better performance.
— indicates that the rate is not presented in this report as the measure was not reported by the MCO or the rate was not displayed in the previous year.

Strengths

Effectiveness of Care: Prevention and Screening Domain

The *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*, *Lead Screening in Children*, and *Breast Cancer Screening* measure indicators were a strength for **UHCCP**. For the *Childhood Immunization Status* measure indicators and *Breast Cancer Screening* measure, **UHCCP** ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 75th percentile benchmark, while the *Lead Screening in Children* measure ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. The *Childhood Immunization Status—Combination 3*, *Combination 7*, 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.[C-1,C-2] In addition, the *Lead Cancer Screening* measure rate demonstrates 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* measure 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]**

[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 1, 2022.

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

Effectiveness of Care: Respiratory Conditions Domain

All *Asthma Medication Ratio*, *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and *Pharmacotherapy Management of COPD Exacerbation* measure indicators were a strength for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. These rates indicate that **UHCCP** 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-3] In addition, **UHCCP** adult members 40 years of age and older are adequately receiving spirometry testing to confirm their COPD diagnosis. Finally, based on the rate, **UHCCP** providers are appropriately prescribing medication to prevent and help members control their COPD related to the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators. **[Quality and Timeliness]**

Effectiveness of Care: Cardiovascular Conditions Domain

The *Controlling High Blood Pressure* measure was a strength for **UHCCP**. For this measure, **UHCCP**'s rate ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-4] **[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**. For these measure indicators, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-5] **[Quality]**

[C-3] 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: Nov 1, 2022.

[C-4] National Committee for Quality Assurance. *Controlling High Blood Pressure*. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Nov 1, 2022.

[C-5] Centers for Disease Control and Prevention (CDC). 2020. "National diabetes statistics report, 2020." Atlanta, GA: U.S. Department of Health and Human Services. Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html. Accessed on: Nov 1, 2022.

Effectiveness of Care: Behavioral Health Domain

For the following measures indicators, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark:

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17*, *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*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—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). 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. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions,[C-6,C-7,C-8] while timely follow-up care for individuals with AOD who were seen in

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[C-6] Griswold, K.S., Zayas, L.E., Pastore, P.A., Smith, S.J., Wagner, C.M., Servoss, T.J. (2018) Primary Care After Psychiatric Crisis: A Qualitative Analysis. *Annals of Family Medicine*, *6(1), 38-43*. doi:10.1370/afm.760.

[C-7] Kyriacou, D.N., Handel, D., Stein, A.C., Nelson, R.R. (2005). Brief Report: Factors Affecting Outpatient Follow-up Compliance of Emergency Department Patients. *Journal of General Internal Medicine, 20(10), 938-942*. doi:10.1111/j.1525-1497.2005.0216_1.x.

[C-8] Bruffaerts, R., Sabbe, M., Demyffenaere, K. (2005). Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *General Hospital Psychiatry, 27, 269-74*.

the ED is associated with a reduction in substance use, future ED use, and hospital admissions.[C-9,C-10,C-11] 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-12] [**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**. For these measures, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. The rate for *Use of Imaging Studies for Low Back Pain* indicates that **UHCCP** 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-13] 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 *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were a strength for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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-14] 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-15] [**Quality, Timeliness, and Access]**

[C-9] Kunz, F.M., French, M.T., Bazargan-Hejazi, S. (2004). Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. *Journal of Studies on Alcohol and Drugs, 65, 363-370*.

[C-10] Mancuso, D., Nordlund, D.J., Felver, B. (2004). Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division.

[C-11] Parthasarathy, S., Weisner, C., Hu, T.W., Moore, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. *Journal of Studies on Alcohol and Drugs, 62, 89-97*.

[C-12] 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: Nov 1, 2022.

[C-13] 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: Nov 1, 2022.

[C-14] CDC Review to Action. (2018). Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Retrieved from: http://reviewtoaction.org/Report_from_Nine_MMRCs.

[C-15] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

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 for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators were a strength for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked at or above NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 50th percentile benchmark. This indicates children within the first 30 months of life were seen by a PCP in order to help influence and assess the early development stages of the child. **[Quality]**

Risk Adjusted Utilization Domain

HSAG did not identify any strengths when conducting the PMV for **UHCCP** within the Risk Adjusted Utilization domain.

Measures Reported Using ECDS Domain

HSAG did not identify any strengths when conducting the PMV for **UHCCP** within the Measures Reported Using ECDS domain.

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 **UHCCP**. For this measure indicator, **UHCCP**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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.[C-16] HSAG recommended that DHHS work with **UHCCP** 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 continuation of the COVID-19 PHE, 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 *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were also a weakness for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 10th percentile benchmark. Untreated chlamydia infections can lead to serious and irreversible complications, including PID, infertility, and increased risk of becoming infected with HIV-1. Screening is important, as

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[C-16] Centers for Disease Control and Prevention (CDC). 2013 "Adolescents and School Health: Childhood Obesity Facts." Available at: https://www.cdc.gov/healthyschools/obesity/index.htm. Accessed on: Nov 1, 2022; and American Heart Association. 2013. "Overweight in Children."

approximately 75 percent of chlamydia infections in women are asymptomatic.[C-17] HSAG continued to recommend that **UHCCP** providers follow up annually with sexually active members through any type of communication such as emails, phone calls, or text messages to ensure members return for yearly screening. If the low rate in members accessing these services is identified as related to the continuing COVID-19 PHE, 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

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Effectiveness of Care: Respiratory Conditions domain.

Effectiveness of Care: Cardiovascular Conditions Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Effectiveness of Care: Cardiovascular Conditions domain.

Effectiveness of Care: Diabetes Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Effectiveness of Care: Diabetes domain.

Effectiveness of Care: Behavioral Health Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Effectiveness of Care: Behavioral Health domain.

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**. For this measure indicator, **UHCCP**'s rate ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 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 continued to recommend 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-18] In addition, HSAG continues to recommend that providers evaluate their noncompliant

[C-17] 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-18] 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: Nov 1, 2022.

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*, and *Initiation of AOD Treatment—Total—Total* measure indicators were a weakness for **UHCCP**. For these measure indicators, **UHCCP**'s rates ranked below NCQA's Quality Compass national Medicaid HMO HEDIS MY 2021 25th percentile benchmark. Treatment has been associated with improved alcohol outcomes, better employment outcomes, and lower criminal justice involvement among people with past criminal history, and reduced mortality among members receiving care.[C-19] 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]**

Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Utilization domain.

Risk Adjusted Utilization Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Risk Adjusted Utilization domain.

Measures Reported Using ECDS Domain

HSAG did not identify any opportunities for improvement when conducting the PMV for **UHCCP** within the Measures Reported Using ECDS domain.

[C-19] National Library of Medicine. Patient Characteristics Associates with Treatment Initiation and Engagement Among Individuals Diagnosed with Alcohol and Other Drug Use in the Emergency Department and Primary Care Settings. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6669120/. Accessed on: Nov 1, 2022.

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

Table C-9 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table C-9—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations for 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. 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 PHE, 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.
Response
Describe initiatives implemented based on recommendations: In 2021, the health plan partnered in a pilot project around chlamydia screening and treatment with an FQHC located in North Omaha. The pilot included promoting screening services via a care message text and postcard to applicable **UHCCP** members. **UHCCP** provided funding to support a dedicated care coordinator for testing and on-site pharmacologic treatment as well as to promote educational campaigns for youth. All providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure. Member adherence reports are included in the Patient Care Opportunity Reports (PCORs) that are made available to providers monthly. The UnitedHealthcare member rewards program offers a $25 incentive to members to schedule and attend appointments to complete chlamydia screenings. We also use our OmniChannel with Pulse program. This focuses on chlamydia gap closure by outreaching to members based on their communication preference. The three methods of outreach include text, IVR, and email.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2021, the health plan noted a slight decrease in chlamydia screening for women ages 16–24. Year over year rates demonstrated a decrease of 0.66 percent for women 16–20 years of age, a decrease of 0.25 percent for women 21–24 years of age, and a decrease of 0.02 percent for women 16–24 years of age.
Identify any barriers to implementing initiatives: Barriers encountered have been associated with access to testing, misinformation (particularly in teenagers), and stigma associated with sexually transmitted infections (STIs).
Identify strategy for continued improvement or overcoming identified barriers: In 2022, the health plan created an incentive pathway for local health departments across the state and all FQHCs to focus on women's reproductive health and preventive screening for STIs.

We have also worked extensively with creating a network of trusted advisors in community roles to speak to various preventive health care needs. The health plan will work with these trusted advisors, particularly those who appeal to the teen population, to help improve the optics of testing and promote healthy sexual activity. The health plan will do a member outreach campaign to our members in the population. In quarter 4 of 2022, the health plan will provide a virtual provider training on women's health, which includes chlamydia screening.
Recommendations for 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. If the low rate of members accessing these services is identified as related to the COVID-19 PHE, 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.
Response
Describe initiatives implemented based on recommendations: Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2021, the health plan noted a decrease in appropriate testing for pharyngitis for members 3–17 years of age. Year over year rates demonstrated a decrease of 1.57 percent for children 3–17 years of age from 2020.
Identify any barriers to implementing initiatives: Barriers include current conflicting guidelines. The use of evidence-based literature such as the Centor criteria makes diagnosis by clinical exam more reliable and in fact, recommends empiric treatment in those with high scores, a practice which is supported by groups such as the Centers for Disease Control and Prevention (CDC), American College of Physicians (ACP), and American Academy of Family Physicians (AAFP). Increased use of telehealth acute visits during the pandemic may have led to more tendency to diagnose based on clinical means, not actual group A strep testing and again, would have some support due to the above-mentioned criteria.
Identify strategy for continued improvement or overcoming identified barriers: The health plan will provide a virtual provider education training on respiratory health. The health plan will be adding a Provider Bulletin to our Provider Portal on appropriate testing for pharyngitis. In quarter 4 of 2022, the health plan will work with Children's Hospital Physicians chief medical officer to understand current processes in their clinics for pharyngitis testing and ask for feedback for educational materials or other interventions that may help with this measure. Materials will be developed depending on the recommendations.
Recommendations 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 SUD after an acute hospitalization, residential treatment, or detoxification visit 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.
Response
Describe initiatives implemented based on recommendations: **UHCCP** has been educating providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and providing resources around appropriate referrals to care via the provider website. A PCP toolkit is also available to educate/remind providers of SUD resources and best practice guidelines. Additionally, a 3-part on-demand series HEDIS training has been provided with a specific segment on SUD measures. Providers can earn free continuing education units (CEUs) to improve awareness of the need for members to be referred to SUD treatment. Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure. Our case managers outreach members post discharge to complete transition of care assessment, medication reconciliation, and address any barriers to follow-up care the member may be experiencing.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **UHCCP** is continuing to monitor claims data for improvement and trends. The final rate for *Follow-Up After High-Intensity Care for Substance Use Disorder MY 2021—Total Follow Up within 7 Days* was 21.78 percent. As of September 20, 2022, the MY 2022 prospective rate is trending higher at 23.88 percent. The final rate for *Follow-Up After High-Intensity Care for Substance Use Disorder MY 2021—Total Follow Up within 30 Days* was 42.33 percent. As of September 20, 2022, the MY 2022 prospective rate is trending higher at 43.26 percent.
Identify any barriers to implementing initiatives: Barriers include limited facility data exchange for timely discharge notification and difficulty in getting members to engage. Limited availability of providers and appointment times for follow up appointments post discharge as well as the use of codes that do not close the gap. Substance abuse confidentiality regulations are one barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent is challenging due to lack of accurate contact information on members, members not responding to outreach, and there is significant difficulty with health plan ability to obtain written consent in a timely manner to impact the short window of time on SUD follow-up treatment needed to improve the specific HEDIS measure. Also, while many providers are making referrals and setting up subsequent SUD treatment for members, some members lack motivation for treatment and may be in denial they have a substance use issue. Therefore, they are not following through with treatment.
Identify strategy for continued improvement or overcoming identified barriers: The health plan will identify providers and offer education. Identify best practices from those who excel on this measure and incorporate in trainings. Incorporate the HEDIS measure in value-based contracting.
Recommendations for 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. 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.

Response
Describe initiatives implemented based on recommendations: The health plan meets monthly with our accountable care organizations (ACOs) to review data and identify a possible contributing factor that many members are being seen in the ED where time constraints may lead to overdiagnosis. All providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2021, the health plan realized a 2.05 percent increase in appropriate treatment for URI for members ages 3 months to 17 years from 2020.
Identify any barriers to implementing initiatives: Provider availability for training sessions.
Identify strategy for continued improvement or overcoming identified barriers: The health plan will post a provider bulletin on the provider portal related to the HEDIS measure and include best practices.
Recommendations for 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 health care spending. 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.
Response
Describe initiatives implemented based on recommendations: **UHCCP** has been educating providers on SBIRT and providing resources around appropriate referrals to care via the provider website. A PCP toolkit is also available to educate/remind providers of SUD resources and best practice guidelines. Additionally, a 3-Part On-Demand Series HEDIS training has been provided with a specific segment on SUD measures. Providers can earn free CEUs to improve awareness of the need for members to be referred to SUD treatment. Prospective IET HEDIS data has been mined and providers have been identified for upcoming trainings. Health services staff outreach each member post discharge to complete a transition of care assessment, medication reconciliation, and assistance with any barriers the member be experiencing. Providers are given annually updated Path Guides to reference HEDIS measure guidelines for gap closure. Member adherence reports are included in the PCORs that are made available to providers on a monthly basis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2021, the health plan noted varied results as they relate to the initiation and engagement of alcohol and other drug abuse or dependence treatment measure. There was a year over year decrease of 2.29 percent for the category of initiation of alcohol and other drug treatment total for ages 13–17 years. However, an increase year over year was noted for initiation of alcohol and other drug treatment for members 18 years of age with an increase in follow-up after high-intensity care for substance use disorder screening for seven-day follow-up total and 30-day follow-up total. Year over year rates demonstrated an 8.70 percent increase for seven-day follow-up total and a 12.33 percent increase for 30-day follow-up from 2020.
Identify any barriers to implementing initiatives: Barriers include limited facility data exchange for timely discharge notification and difficulty in getting members to engage. Limited availability of providers and

appointment times for follow-up appointments post discharge with a short turn-around time to complete follow-up visits. Substance abuse confidentiality regulations are one barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent is challenging due to lack of accurate contact information on members, members not responding to outreach, and there is significant difficulty with health plan ability to obtain written consent in a timely manner to impact the short window of time on SUD follow-up treatment needed to improve the specific HEDIS measure. Also, while many providers are making referrals and setting up subsequent SUD treatment for members, some members lack motivation for treatment and may be in denial they have a substance use issue. Therefore, they are not following through with treatment.
Identify strategy for continued improvement or overcoming identified barriers: Provider education is planned for IET initiation and engagement in quarter four of 2022.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table C-10—Compliance With Regulations—Trended Performance for UHCCP

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**UHCCP Results**	
Standard I—Enrollment and Disenrollment	86%	100%
Standard II—Member Rights and Confidentiality	100%	
Standard III—Member Information	82%	
Standard IV—Emergency and Poststabilization Services	100%	100%
Standard V—Adequate Capacity and Availability of Services	100%	
Standard VI—Coordination and Continuity of Care	100%	
Standard VII—Coverage and Authorization of Services	89%	
Standard VIII—Provider Selection and Program Integrity	94%	94%
Standard IX—Subcontractual Relationships and Delegation	100%	75%
Standard X—Practice Guidelines	100%	100%
Standard XI—Health Information Systems	100%	100%
Standard XII—Quality Assessment and Performance Improvement	100%	100%
Standard XIII—Grievance and Appeal System	92%	

*Bold text indicates standards that HSAG reviewed during CY 2022–2023.

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

Table C-11 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 2022–2023.

Table C-11—Summary of UHCCP Scores for the CY 2022–2023 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	77	1	12	99%
Totals	**190**	**166**	**165**	**1**	**24**	**99%**

* 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, Timeliness, and Access]**

Five out of the seven standards reviewed during CY 2022–2023 met 100 percent compliance and HSAG identified no required actions. Additionally, **UHCCP** scored 100 percent compliance on the credentialing record reviews. **[Quality, Timeliness, and Access]**

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

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

UHCCP achieved full compliance in the Practice Guidelines standard, demonstrating that 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 that 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 that the MCE had maintained a well-developed, thorough, and continuous QAPI program. **UHCCP**'s program outlined activities such as PIPs, 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, Timeliness, and Access]**

UHCCP received a score of 94 percent in the Provider Selection and Program Integrity standard and 99 percent on the recredentialing record reviews. **UHCCP** maintained a credentialing and recredentialing plan. The plan outlined the process for recredentialing that complies with the requirements of the contract to ensure that the decisions are made and communicated on a timely basis. However, during the recredentialing sample record review, HSAG identified one file that reflected a delay from the recredentialing approval to notification to the provider that exceeded five months. HSAG recommended that **UHCCP** provide timely notification to providers once a recredentialing decision has been made. **[Quality, Timeliness, and Access]**

During the sample record review, HSAG determined that one file exceeded the recredentialing time period of 36 months. **UHCCP** must follow its documented process for recredentialing within 36 months, which complies with the requirements of the contract. **[Quality, Timeliness, and Access]**

UHCCP received a score of 75 percent in the Subcontractual Relationships and Delegation standard. HSAG recommended that **UHCCP** consistently include the Nebraska Medicaid Regulatory Appendix in its agreements to include all delegated entity requirements within the Nebraska Medicaid contract. During HSAG's review, the Nebraska Medicaid State Regulatory Appendix was not included in either of the two sample agreements provided. **UHCCP**'s two agreements did not include all provisions required by federal regulations and **UHCCP**'s contract with DHHS. **[Quality]** **UHCCP** must ensure that all contracts and written agreements specify the following provisions:

- 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.

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

Table C-12 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

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

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.
Response
Describe initiatives implemented based on recommendations: **UHCCP** received the Contract Year 2021–2022 Compliance Review Report on December 17, 2021. Responses to all required corrective actions were due on February 15, 2022, in the form of the completed CAP template. **UHCCP** has a comprehensive process for tracking any issues identified in an audit or other regulatory review. This Corrections process includes tracking of each issue in an internal data warehousing system until the item is completed. In order to close out an item there must be evidence of completion, such as a revised letter, new training content, etc. This evidence is also stored in the internal data warehousing system. A staff person on the Corrections team monitors each item with the subject matter experts to ensure timely submission of all required elements to the applicable regulatory entity. This commitment to timely completion of corrective actions positively impacts member outcomes for any corrective actions that involve a member-facing process. In this case, utilizing the Corrections process resulted in all required responses being submitted to HSAG on February 14, 2022.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable. The submission of the CAP template was made on time on February 14, 2022.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** will continue to use its internal Corrections process to track corrective actions to completion so that future audit deliverables continue to be submitted in a timely manner.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: • **UHCCP** updated the Initiated Member Disenrollment Policy to reflect the appropriate language as provided in 42 CFR §438.56(b)(2). • Training required: Updated policy was distributed to leaders in Operations, Health Services, Member Service, and Provider Service.

Any proposed terminations will be checked and approved by the compliance officer, chief operating officer, or chief executive officer prior to submission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
Identify any barriers to implementing initiatives: No barriers identified to completing initiatives.
Identify strategy for continued improvement or overcoming identified barriers: • Staff training required: Updated policy was distributed to leaders in Operations, Health Services, Member Service, and Provider Service. • Any proposed terminations will be checked and approved by the compliance officer, chief operating officer, or chief executive officer prior to submission.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: Initiatives to update its member handbook, welcome materials, the provider directory, and preferred drug list, to include a tagline with all required information. • Provider Directory—Page 3 of the provider directory was updated to include a large font size tagline. The statements in English and non-English languages included about translation services, printed materials, and alternative audio formats were updated to clarify that these options are free. • Member Handbook—Page 7 of the member handbook was updated to include large font size details for the hearing impaired, translation, and printing services; updated to clarify these materials are at no cost to the member; updated to reflect details in English and in non-prevalent language (Spanish). • Member Handbook—Page 107 of the member handbook was updated to include a large font statement about free services for language translation and large print materials, including details about auxiliary aids. • The Getting Started Guide—Updated to include information on the last page, to inform members about translation services or alternative formats available to the member at no cost. • Preferred Drug List/Formulary—The Preferred Drug List was updated to include large print information in the non-English prevalent language. Initiatives to 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.

- The Getting Started Guide was updated to include information on the last page, to inform members of their right to request and receive written materials within five business days of the request.
- The Member Handbook was updated to inform members of their right to request and receive written materials within five business days of the request, reflected on page 13.

Initiatives to update materials that are sent to the member within 10 business days of enrollment to include all required information about printed materials, and HSAG recommends including a more direct link to the member handbook

- The Getting Started Guide was updated to include information on the last page, with a link directly to the online member handbook and notifying members of their right to request a printed version of the handbook and directions for how to obtain a copy.

Initiatives to update the member handbook to provide accurate information regarding the grievance, appeal, and State fair hearing procedures and time frames.

- The Member Handbook was updated to provide accurate information regarding the grievance, appeal, and State fair hearing procedures and time frames.
- Training required: The handbook was circulated for awareness on 02/14/2022.
- During future handbook updates, the appeal and grievance section will be carefully reviewed for federal compliance and if contract and federal differences are identified, the plan will pursue the alignment with MLTC.

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

- HSAG viewed **UHCCP**'s revised materials and observed that it included the tagline with all required information and was placed in a prominent location. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
- HSAG viewed **UHCCP**'s member handbook and Getting Started Guide and noted that they informed members of their right to request and receive written materials within five business days. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
- HSAG reviewed the Getting Started Guide and noted that website URL is now listed. HSAG also viewed **UHCCP**'s Getting Started Guide and confirmed that it included all required information about printed materials. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
- HSAG reviewed the updates within the member handbook and noted that the grievance and State fair hearing sections of its member handbook now include messaging that assistance is available in completing grievances and State fair hearing forms. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.

Identify any barriers to implementing initiatives: • Initiatives completed with no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: During future handbook updates, the A&G section will be carefully reviewed for federal compliance and if contract and federal differences are identified, the plan will pursue the alignment with MLTC.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: Initiatives to ensure that initial requests for service considered expedited requests are processed, with determination made and notification sent, within 72 hours. • Addition of full-time employee • The inpatient (IP) review process was adjusted, which includes bundling days and leaders managing paid time off (PTO) and prioritization of case volume timely. • Additionally, **UHCCP** staff mentioned that the new process now allows the reviewers to organize their work according to timelines and that a new dashboard was developed for monitoring all cases and due dates. • Training required: Staff were coached on the NE turnaround times to ensure compliance to the turnaround time is met. The MCE has and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions: "If the provider indicates, or the MCE determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the MCE makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service." Initiatives to ensure that initial requests for service considered expedited requests are processed, with notification sent within 72 hours of the ABD. • Addition of full-time employee • The IP review process was adjusted, which includes bundling days and leaders managing PTO and prioritization of case volume timely. • Training Required: Staff were coached on the NE turnaround times to ensure compliance to the turnaround time is met. The MCE has and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions: 'If the provider indicates, or the MCE determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the MCE makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service.' Decision overturn as a result of the reconsideration or peer-to-peer review:

When a Nebraska decision is overturned as a result of a peer to peer, an overturn letter is sent to the member. A copy of the overturn template is attached.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): No additional turnaround time errors identified.
Identify any barriers to implementing initiatives: No barriers in remediation
Identify strategy for continued improvement or overcoming identified barriers: Turnaround times are monitored in real time and within regular compliance reporting. Internal end-to-end audits are conducted monthly to ensure compliance with the Nebraska rules.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: • **UHCCP** created the Network Policy 1_NE_EQRO_NM-020 Network Selection and Retention that explains the process that **UHCCP** is currently using to select and retain providers. • **UHCCP** has provided current policies 1_NE_EQRO_NM-004 Provider Communications and 1_NE_EQRO_NM-009 Provider Education and Training which describe the process of maintaining open communication, working with our provider advocate team, developing strong collaborative provider relationships, and policy to provide education and training. • Monitoring the retention of providers in our network is achieved through relationships with providers and network analysis. **UHCCP** monitors the network quarterly and annually in our Network Development plan.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): HSAG reviewed the draft Network Selection and Retention policy and procedure and noted that the policy described all processes **UHCCP** implemented for provider retention. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
Identify any barriers to implementing initiatives: Initiatives completed with no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: Monitoring the retention of providers in our network is achieved through relationships with providers and network analysis. **UHCCP** monitors the network quarterly and annually in our Network Development plan.
Recommendations
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 members 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.

Response

Describe initiatives implemented based on recommendations:

Initiatives to 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.

- The Care Provider Manual was updated to remove: "For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing." (Page 104 in Chapter 12).
- UCSMM 07.12 Policy was updated to remove language that states: 'For standard appeals, the member or provider must follow a verbal filing with a written signed appeal.'
- The Member Appeal and Grievance Policy was updated to remove the language: "Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal."

Initiatives to change its applicable policy 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 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.

- UCSMM.07.11 Appeal Review Timeframes Policy was updated to remove the language that states 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.
- **UHCCP** reviewed its member-specific communications to ensure accuracy of depicting when the request for a State fair hearing must be filed. The current NABD documents include:

  You must ask for a State fair hearing within 120 calendar days from the date of UnitedHealthcare Community Plan's appeal decision. The request must be postmarked within 120 calendar days from the date of the **appeal decision notice.**

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

- HSAG reviewed the documents submitted as evidence of completion. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
- HSAG reviewed the documents submitted as evidence of completion. Following a review of the CAP and supporting documentation, HSAG has determined that the information provided is sufficient to demonstrate

completion of all required actions and compliance with the related requirements. HSAG requires no further response from **UHCCP** for this requirement at this time.
Identify any barriers to implementing initiatives: Initiatives completed with no barriers identified.
Identify strategy for continued improvement or overcoming identified barriers: • **UHCCP**'s provider manual included all required information to inform providers about the Medicaid and CHIP member grievance and appeal system. **UHCCP** will update the Provider Manual based upon HSAGs recommendation 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. • To avoid potential misunderstanding of the differences between a grievance and an appeal and the processes use to resolve each, **UHCCP** will provide a training session for providers to review this process and remind physicians that the narrative added into the system must be easy for members to understand. • **UHCCP** will have a separate form for members to use for submitting a grievance and an appeal in 2022.

Validation of Network Adequacy

Results

Network Capacity Analysis

Table C-13 displays the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for **UHCCP**. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYN were limited to female members 15 years of age and older.

Table C-13—Statewide Population of Eligible Members for UHCCP

Member Population	UHCCP
Children 18 Years and Younger	65,748
Females 15 Years and Older	43,113
All Members*	125,386

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

Table C-14 displays the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for **UHCCP**.

Table C-14—Statewide Network Capacity Analysis Results for UHCCP*

Provider Category**	UHCCP	
	Providers	Ratio***
PCPs	1,894	1:67
High Volume Specialists:**		
Cardiologists	109	1:1,151
Neurologists	58	1:2,162
OB/GYNs	197	1:219
Oncologists/Hematologists	53	1:2,366
Orthopedics	133	1:943
Pharmacies	417	1:301
Behavioral Health Inpatient and Residential Service Providers	5	1:25,078
Behavioral Health Outpatient Assessment and Treatment Providers	791	1:159
Hospitals	100	1:1,254

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** Providers include those serving all ages as well as those serving age-specific segments of the population. Member-to-provider ratios could be much higher for child members to pediatric providers, for example, than for adult members to providers that primarily serve adults

*** In calculating the ratios, all covered members were considered except in the case of OB/GYNs, where the member population was limited to female members 15 years of age and older.

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

Geographic Network Distribution Analysis

Nebraska has set geographic access standards for most providers in terms of distance in miles, apart from Hospitals for which the standard is defined in terms of time in minutes.

Table C-15 displays the percentage of **UHCCP**'s members with access to their provider network according to the geographic access standards established by DHHS.

Table C-15—Percentage of Members With Required Access to Care by Provider Category and Urbanicity for UHCCP*

Provider Category	Urbanicity**	UHCCP
		Percentage of Members With Required Access
PCPs	Urban	>99.9%
	Rural	100.0%
	Frontier	100.0%

Provider Category	Urbanicity**	UHCCP Percentage of Members With Required Access
High Volume Specialists* **		
Cardiologists	Statewide	99.1%
Neurologists	Statewide	94.9%
OB/GYNs	Statewide	99.8%
Oncologists/Hematologists	Statewide	99.4%
Orthopedics	Statewide	99.5%
Pharmacies	Urban (90%)	96.3%
	Rural (70%)	90.7%
	Frontier (70%)	98.2%
Behavioral Health Inpatient and Residential Service Providers	Urban	97.3%
	Rural	97.4%
	Frontier	90.2%
Behavioral Health Outpatient Assessment and Treatment Providers	Urban	99.9%
	Rural	97.6%
	Frontier	97.9%
Hospitals	Statewide	98.7%

* Red cells indicate that minimum geographic access standards were not met by **UHCCP** for a specific provider category in a specific urbanicity.

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

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

Table C-16 displays the percentage of **UHCCP**'s members with the access to care required by contract standards for behavioral health categories by region.

Table C-16—Percentage of Members With Required Access to Behavioral Health Services by Provider Category and Region for UHCCP*

Region	UHCCP Percentage of Members With Required Access
Behavioral Health Inpatient and Residential Service Providers	
Region 1	100.0%
Region 2	49.7%
Region 3	99.4%
Region 4	99.8%
Region 5	100.0%
Region 6	100.0%
Behavioral Health Outpatient Assessment and Treatment Providers	
Region 1	100.0%
Region 2	98.4%
Region 3	100.0%
Region 4	94.9%
Region 5	100.0%
Region 6	100.0%

*Red cells indicate that minimum geographic access standards were not met by an MCO for a specific provider category in a specific Behavioral Health Region.

Table C-17 identifies the counties where the minimum geographic access standards were not met by **UHCCP** in a specific urbanicity or Behavioral Health Region for each applicable provider category.

Table C-17—Counties Not Meeting Standards for UHCCP by Urbanicity and Behavioral Health Region

Provider Category	Counties Not Meeting Standard*
PCPs	
Urban	Lincoln
PCPs, Pediatric	
Urban	Lincoln
Rural	Cherry
Frontier	Grant, Hooker
High Volume Specialists†**	
Cardiologists	Boyd, Brown, Cherry, Dawes, Dundy, Grant, Holt, Keya Paha, Loup, Rock, Sheridan

Provider Category	Counties Not Meeting Standard*
Neurologists	Banner, Box Butte, Boyd, Brown, Cherry, Cheyenne, Dawes, Deuel, Dundy, Garden, Grant, Holt, Keya Paha, Kimball, Loup, Morrill, Rock, Scotts Bluff, Sheridan, Sioux
OB/GYNs	Brown, Cherry
Oncologists/Hematologists	Boyd, Brown, Cherry, Holt, Hooker, Keya Paha, Rock
Orthopedics	Brown, Cherry, Holt, Keya Paha, Rock
High Volume Specialists, Pediatric†**	
Cardiologists, Pediatric	Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Chase, Cherry, Cheyenne, Custer, Dawes, Deuel, Dundy, Gage, Garden, Grant, Hayes, Hitchcock, Holt, Hooker, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Red Willow, Richardson, Rock, Scotts Bluff, Sheridan, Sioux, Thomas
Neurologists, Pediatric	Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Holt, Hooker, Howard, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Perkins, Phelps, Pierce, Platte, Red Willow, Richardson, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thomas, Valley, Wayne, Wheeler
Oncologists/Hematologists, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, York
Orthopedics, Pediatric	Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Cedar, Chase, Cherry, Cheyenne, Clay, Custer, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nuckolls, Perkins, Phelps, Pierce, Platte, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Valley, Wayne, Webster, Wheeler, York
Pharmacies	
Urban	Buffalo, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Clay, Custer, Furnas, Harlan, Thurston
Frontier	Grant, Hooker, Thomas

Provider Category	Counties Not Meeting Standard*
Behavioral Health Inpatient and Residential Service Providers	
Urban	Lincoln
Rural	Cherry, Furnas, Red Willow
Frontier	Dundy, Frontier, Hayes, Hitchcock, Hooker, McPherson
Region 2	Dundy, Frontier, Hayes, Hitchcock, Hooker, Lincoln, McPherson, Red Willow
Region 3	Furnas
Region 4	Cherry
Behavioral Health Outpatient Assessment and Treatment Providers	
Urban	Lincoln, Madison, Platte
Rural	Boone, Cedar, Cherry, Knox
Frontier	Dundy, Grant, Hooker, Thomas
Region 2	Dundy, Grant, Hooker, Lincoln, Thomas
Region 4	Boone, Cedar, Cherry, Knox, Madison, Platte
Behavioral Health Outpatient Assessment and Treatment Providers, Pediatric	
Urban	Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Burt, Butler, Cedar, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dawes, Dixon, Fillmore, Furnas, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Saline, Stanton, Thayer, Thurston, Valley, Wayne, Webster, York
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Franklin, Frontier, Garden, Garfield, Gosper, Grant, Greeley, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sherman, Sioux, Thomas, Wheeler
Region 1	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
Region 2	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
Region 3	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
Region 4	Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne
Region 5	Butler, Fillmore, Gage, Jefferson, Johnson, Nemaha, Pawnee, Polk, Richardson, Saline, Thayer, York

Provider Category	Counties Not Meeting Standard*
Region 6	Dodge
Hospitals**	
Hospitals	Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Cedar, Cherry, Cheyenne, Clay, Custer, Dawes, Dixon, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Holt, Hooker, Keya Paha, Lincoln, Logan, Loup, McPherson, Sheridan, Sherman, Sioux, Thomas, Thurston, Wheeler

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

Strengths

UHCCP achieved compliance with five network access standards by urbanicity and seven behavioral health access standards by Behavioral Health Region. **[Access]**

UHCCP achieved at least 98 percent compliance with seven network access standards by urbanicity and three behavioral health access standards by Behavioral Health Region. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

UHCCP's greatest opportunity for improvement is to strengthen its network of Behavioral Health Inpatient and Residential Services Providers available to Behavioral Health Regions, particularly in Region 2, and Behavioral Health Outpatient Providers in Behavioral Health in Region 4. **[Quality, Timeliness, and Access]**

In addition, **UHCCP** could significantly improve access to pediatric specialists across all provider types and regions. **[Quality, Timeliness, and Access]**

For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Quality, Timeliness, and Access]**

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

Table C-18 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table C-18—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: Our Provider Data Analytics and Delivery (PDAD) team facilitates data remediation, which includes identifying data errors, creating error reports, and partnering with data loading teams to support research and remediation in our provider data systems. We identify data errors during provider file creation and write them to an error report. We identify errors via the response or rejection reports from the state. PDAD submits error reports to data loading teams to research and update source systems in a timely manner.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): A Review of the report that **UHCCP** submitted in 2021 found some interpretation differences in what **UHCCP** reported versus what HSAG was expecting in the requested format. As this was the first request Network Data Validation Request, **UHCCP** has implemented changes in the report in 2022 and has seen improvements. Additionally, **UHCCP**'s in-depth review of HSAG's findings and the report that **UHCCP** submitted in 2021 show improved percentages that we outline in our response below.
Identify any barriers to implementing initiatives: None**.**
Identify strategy for continued improvement or overcoming identified barriers: UHCCP will work with our (PDAD team to facilitate data remediation, which includes identifying data errors, creating error reports, and partnering with data loading teams to support research and remediation in our provider data systems.
Recommendations
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. • 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. • 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 these data, they were not provided in the format requested and therefore could not be measured in this analysis. • 92.8 percent of provider records contained no entries in the provider type data field. While HSAG is confident that **UHCCP** has these data, they were not provided in the format requested and therefore could not be measured in analysis. • 6.2 percent of provider service location addresses could not be standardized to a valid postal address. MCEs should maintain complete and accurate data regarding provider service locations. • 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 these data, they were not provided in the format requested and therefore could not be measured in this analysis.

Response
Describe initiatives implemented based on recommendations: **UHCCP** conducted an in-depth review of HSAG's findings and the report that **UHCCP** submitted. Below is a summary of our findings. • Gender: **UHHCP** found an error with the report that the provider type was not identified to clarify facility records from practitioner records. A review of the report that **UHCCP** submitted in 2021 had a total of 17,595 records. There were 2,054 facility or clinic records that did not have a gender. There was a total of 15,541 practitioner records submitted with 15,238 (98.1 percent) having the gender identified. There were 303 (1.9 percent) practitioner records that did not have a gender identified. The report has been corrected. • New Patient Indicator: **UHCCP** found an error with the report that the provider type was not identified to clarify facility records from practitioner records. A Review of the report that **UHCCP** submitted in 2021 shows that 15,234 (98.0 percent) of practitioners had a value for the New Patient Indicator and 307 (2.0 percent) did not. **UHCCP** has worked with our PDAD team to correct data loading errors. • Provider Specialty: A review of the report that **UHCCP** submitted in 2021 found that the report included Provider Specialty for Facility records in the Provider Type field. This was corrected in the 2022 submission with a percent Present and Valid Values of 99.9 percent. • Provider Type: **UHCCP** reviewed HSAG's findings that 92.8 percent of provider records did not contain entries in the provider type data field. **UHCCP**'s review of the data revealed this was a reporting error. **UHCCP** has reviewed the data and reports that 15,541 have a provider type of Practitioners and 2,054 have a provider type of Facility. This was corrected in the 2022 submission with the provider type data field having valid values of 99.9 percent. • Location Address: A review of the report that **UHCCP** submitted in 2021 for service address had 680 (3.9 percent) records with the University of Nebraska Medical Center with an address of 42nd and Emile, Omaha, Nebraska 68198. While this is not a postal address, it is the location the Medical Center uses on their website as an address for their campus. **UHCCP** has implemented a process to review the entire list of addresses to verify if the record has a valid postal address and make corrections accordingly. • Language: A review of the report that **UHCCP** submitted in 2021 confirms HSAG's findings that **UHCCP** submitted a language field that contained alternative-language data. **UHC**CP agrees that data regarding primary languages spoken by providers are important for identifying potential language barriers to care for members. **UHCCP** has reviewed our Provider Directory to confirm that primary language spoken for each provider is reported in the provider directory. **UHCCP** review confirms this is a reporting error and not a data load error.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): A Review of the report that **UHCCP** submitted in 2021 found some interpretation differences in what **UHCCP** reported versus what HSAG was expecting in the requested format. As this was the first Network Data Validation Request, **UHCCP** has implemented changes in the report in 2022 and has seen improvements. Additionally, **UHCCP**'s in-depth review of HSAG findings and the report that **UHCCP** submitted in 2021 show improved percentages that we outlined above.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: **UHCCP** will work with our PDAD team to facilitate data remediation, which includes identifying data errors, creating error reports, and partnering with data loading teams to support research and remediation in our provider data systems.

Validation of Performance Improvement Projects

Results

MCNA submitted one PIP, *First Dental Visit at Age 1,* focused on increasing the percentage of members who receive at least one dental service by their first birthday, for the 2022–2023 validation cycle. The PIP received an overall *Met* validation status with the initial submission. The MCE did not resubmit. Table D-1 summarizes **MCNA**'s PIP validation scores.

Table D-1—2022–2023 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
First Dental Visit at Age 1	Initial Submission	100%	100%	*Met*
	Resubmission	*Did Not Resubmit*		

Overall, 100 percent of all applicable evaluation elements received a score of *Met*. Table D-2 presents baseline and Remeasurement 1 performance indicator data for **MCNA**'s *First Dental Visit at Age 1* PIP, which were used to objectively assess for improvement.

Table D-2—Performance Indicator Results for MCNA's *First Dental Visit at Age 1* PIP

Performance Indicator	Baseline (01/01/2020 to 12/31/2020)		Remeasurement 1 (01/01/2021 to 12/31/2021)		Remeasurement 2 (01/01/2022 to 12/31/2022)		Sustained Improvement
1. Percentage of members 1 year of age who received their first dental visit by their first birthday.	N: 366	3.51%	N: 497	4.73%	N: NA	NA	*Not Assessed*
	D: 10,420		D: 10,504		D: NA		
2. Percentage of members 1 year of age who received a preventive visit by their first birthday.	N: 297	2.85%	N: 455	4.33%	N: NA	NA	*Not Assessed*
	D: 10,420		D: 10,504		D: NA		

N–Numerator D–Denominator
NA–Not Applicable

For the baseline measurement period (calendar year [CY] 2020), **MCNA** reported that 3.51 percent of members 1 year of age received a dental visit on or before their first birthday and 2.85 percent of members in this age group received at least one *preventive* dental service on or before their first birthday.

For the first remeasurement period (CY 2021), **MCNA** reported a statistically significant increase over baseline results for performance indicators 1 and 2. For Indicator 1, the DBM reported an increase of 1.22 percentage points in the percentage of members who received their first dental visit by their first birthday, from 3.51 percent to 4.73 percent ($p < 0.0001$). For Indicator 2, the DBM reported an increase of 1.48 percentage points in the percentage of members who received their first preventive dental visit by their first birthday, from 2.85 percent to 4.33 percent ($p < 0.0001$). Sustained improvement in performance indicator results cannot be assessed until results from the second remeasurement period are reported.

Interventions

For the *First Dental Visit at Age 1* PIP, **MCNA** used a fishbone diagram and results of PDSA cycles to identify the following barriers and interventions for improving performance indicator outcomes.

Table D-3 displays the barriers to improvement that **MCNA** identified and the interventions **MCNA** initiated to address those barriers.

Table D-3—Barriers and Interventions for MCNA's *First Dental Visit at Age 1* PIP

Barriers	Interventions
Limited oral health literacy among parents and/or caregivers of members under 1 year of age	• Member/caregiver educational "Baby's First Toothbrush Kit" which was mailed to families when a child member turned 10 months of age. The kit included oral health educational content, a baby toothbrush, and information about scheduling the first dental checkup by the first birthday. • Postcards and text messages sent to parents reminding them to schedule the first dental visit before the child's first birthday.
Lack of awareness and/or adherence to preventive care clinical practice guidelines (CPGs) among providers.	Practice Site Performance Summary (PSPS) report distributed to providers quarterly, which included facility feedback and peer performance on the rate of 1-year-old members who had received a preventive dental service.

Strengths

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

- **MCNA** followed a methodologically sound PIP design for the baseline and Remeasurement 1 periods that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality, Timeliness, and Access]**

- **MCNA** reported accurate indicator results and appropriate data analyses and interpretations of results. **[Quality, Timeliness, and Access]**
- **MCNA** conducted barrier analyses to identify and prioritize barriers to improvement and initiated interventions to address priority barriers. **[Quality, Timeliness, and Access]**
- **MCNA** reported performance indicator results that demonstrated statistically significant improvement from baseline to Remeasurement 1. **[Quality, Timeliness, and Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

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

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

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. **[Quality, Timeliness, and Access]**
- Use ongoing collection of intervention evaluation results to support continued refinement of improvement strategies and maximize improvement in performance indicator outcomes. **[Quality, Timeliness, and Access]**
- Identify strategies to continue and spread successful interventions to support sustained and further improvement in performance indicator outcomes over time. **[Quality, Timeliness, and Access]**

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

Table D-4 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table D-4—Follow-Up on Prior Year's Recommendations for Performance Improvement Projects

Recommendations
Use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. The DBM should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.
Response
Describe initiatives implemented based on recommendations: **MCNA** used PDSA cycles to evaluate the effectiveness of each intervention reported on the *First Dental Visit at Age 1* PIP that was submitted on 04/29/2022. A copy of the PDSA cycles was submitted to HSAG and **MCNA** received a PIP validation score of 100 percent. **MCNA** will continue to use PDSA cycles to monitor the impact of the intervention(s) and modify interventions as needed in the current and any future PIPs.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
Revisit causal//barrier analyses at least annually to ensure the identified barriers and opportunities for improvement are still applicable.
Response
Describe initiatives implemented based on recommendations: MCNA revisited the causal/barrier analysis on the 2022 annual submission of the *First Dental Visit at Age 1* PIP submitted on 04/29/2022 and it was documented within Step 8 of the PIP form that it remained consistent with the baseline narrative and there were no changes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
Response
Describe initiatives implemented based on recommendations: MCNA utilized the fishbone diagram, this was documented in Step 8 of the PIP form and a copy was submitted to HSAG in the 4/29/2022 submission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.

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 near-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 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 enrollees 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 attempted to identify duplicate enrollees 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 enrollee record to ensure that each unique member was counted only once 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.

MCNA received electronic claims from providers via **MCNA**'s provider portal and through an intermediary or clearinghouse, or in hard-copy format via mailed paper forms sent directly to the **MCNA** vendor Smart Data Solutions (SDS). Claims received via clearinghouse and through the provider portal were transferred into DentalTrac. Upon receipt of paper claims, **MCNA**'s vendor, SDS, converted the paper claims to an 837D file format, and the claims were processed using the same process as electronic claims, ensuring promptness and accuracy. SDS would provide to **MCNA** the provider paper claims that were converted to a standard 837D electronic format via the SFTP site daily. Roughly 96 percent of the claims were received electronically, and 61.69 percent of claims were auto-adjudicated. SDS securely stored paper claims for 90 days before shredding them.

Claims and encounters were subjected to a built-in pre-adjudication validation process managed by **MCNA** staff members, whereby claims/encounters were required to receive a 95 percent procedural accuracy rate and a 97 percent financial accuracy rate. Validation audits were also conducted at processor and plan levels. The claims auditing team performed monthly audits on the adjudication system to ensure accuracy. Additionally, **MCNA**'s program integrity team reviewed claims and pre-authorizations as part of the standard claims process to ensure accuracy of the claims. If discrepancies were found, they were communicated to the examiner for resolution.

Following claims adjudication, service data were batched, translated into EDI 837 transaction files, and submitted to the State daily. **MCNA** retrieved 999 and 4950 response files to determine whether files or records were rejected and the reason for the rejection. **MCNA** staff members would forward any errors to the appropriate **MCNA** internal business unit for correction or review. Approximately 99.8 percent of encounters were accepted by the State.

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 Microsoft's Power BI business intelligence reporting tool to generate the performance measure rates based on the enrollment and claims stored and maintained in DentalTrac. **MCNA** used the PostgreSQL database to house all scripts, tables, and queries related to rate production. **MCNA** used the Power BI business intelligence tool to store all query output. The business intelligence tool allowed **MCNA** end users from its business intelligence team to perform ongoing review and oversight of the data. The **MCNA** quality 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 information technology (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

Based on all validation activities, HSAG determined results for each performance measure. The CMS PMV protocol identifies possible validation finding designations for performance measures, which are defined in Table D-5.

Table D-5—Designation Categories for Performance Measures

Designation	Description
Reportable (R)	Measure was compliant with State specifications.
Do Not Report (DNR)	DBM rate was materially biased and should not be reported.
Not Applicable (NA)	The DBM was not required to report the measure.
Not Reported (NR)	Measure was not reported because the DBM did not offer the required benefit.

According to the CMS PMV protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of "DNR" because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of "R."

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure as "DNR."

Table D-6 shows the key review findings and audit designations for **MCNA** for each performance measure rate.

Table D-6—Review Designations for MCNA

Performance Measure	Measure Designation
ADV: Annual Dental Visit—*The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*	R

Performance Measure	Measure Designation
TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services—*The percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least two topical fluoride applications within the reporting year.*	R
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.*	R
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.*	R
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.*	R
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.*	R

Table D-7—MY 2020 and 2021 Performance Measure Results for MCNA

Performance Measure	MY 2020 Rate	MY 2021 Results		
		Denominator	Numerator	Rate
ADV: Annual Dental Visit—*The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.*	43.48%	20,027	9,159	45.73%
ADV: Annual Dental Visit—*The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.*	61.64%	29,416	19,453	66.13%
ADV: Annual Dental Visit—*The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.*	65.25%	37,444	25,880	69.12%
ADV: Annual Dental Visit—*The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.*	59.62%	36,939	22,681	61.40%
ADV: Annual Dental Visit—*The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.*	51.13%	31,955	16,491	51.61%
ADV: Annual Dental Visit—*The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.*	37.71%	11,065	3,780	34.16%
ADV: Annual Dental Visit—*The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.*	57.03%	166,846	97,444	58.40%

Performance Measure	MY 2020 Rate	MY 2021 Results		
		Denominator	Numerator	Rate
TFL-CH-A: Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services—*The percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least two topical fluoride applications within the reporting year.*	NR	69,410	24,642	35.50%
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.*	50.38%	197,319	104,037	52.73%
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.*	16.36%	197,319	36,218	18.36%
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.*	46.92%	197,319	97,451	49.39%
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.*	40.77%	164,447	60,895	37.03%

NR indicates that the measure was not selected for review during the measurement year.

Strengths

MCNA denoted spending a substantial amount of time supporting its provider network. **MCNA** received approximately 3,000 emails a month addressing questions submitted by its providers. **MCNA** provided monthly newsletters, provider bulletins, email blasts, and reference materials to its network providers to help keep them up to date on any industry trends. In addition, **MCNA** hosted a quarterly seminar for providers to address any individual questions live and for providers to generate any feedback to **MCNA** directly. **MCNA**'s Provider Relations Department also reached out to providers individually and presented updates on how the providers were performing on specific measure metrics in comparison to similar providers in their area. **[Quality]**

Additionally, **MCNA**'s provider portal served as an all-inclusive resource site for providers to submit claims and access provider manuals and bulletins, listed a directory of **MCNA** contacts to help address

any concerns, housed additional forms for submission, and offered links to **MCNA**’s YouTube channel that hosts instructional tutorials for provider references. **[Quality]**

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 2022 PMV review. **[Quality]**

MCNA noted during the review that it is continuing to exercise HSAG’s recommendation from last year as **MCNA** works with its provider network to identify optimal office hours to ensure members can receive preventive services. Additionally, **MCNA** is continuing to monitor its rates over time to identify pandemic rate impact, ensuring lower access to preventive care is not being driven by a non-pandemic issue. **MCNA** indicated that it is in constant contact with providers to ensure member access is a priority. A backlog of patients still exists for many providers as a result of the PHE, but **MCNA** stated the backlog is slowly being reduced based on member availability and member priorities to attend appointments. **MCNA** is anticipating the backlog will be alleviated by August 2023. **[Quality, Timeliness, and Access]**

For MY 2021, **MCNA**’s rates for the NCQA *Annual Dental Visit—19–20 Years of Age* and for the DQA *Care Continuity, Dental Services* measures decreased. **MCNA** contributed the *Annual Dental Visit—19–20 Years of Age* rate decrease to a volatile age group. **MCNA** noted that members in this age group typically lack parental supervision and are less likely to follow up on services conducted during their adolescence. **MCNA** also discussed that the *Care Continuity, Dental Services* measure rate decrease was due to office closures and members seeing a different practice based on service availability. Members under the *Care Continuity, Dental Services* measure would not have been counted toward the numerator for the measure if members did not follow up with the same practice for consecutive services. HSAG recommended that **MCNA** work with providers to illustrate the importance of scheduling members immediately after they receive dental services to ensure an appointment has been set before they leave the office. After members leave the office, it becomes difficult to schedule them through follow-up communications. With a backlog of scheduled patients, providers should try to schedule college-aged members during time frames most convenient for that age group, taking personal schedules into consideration (e.g., school, work) to optimize their availability. **MCNA** should also remind providers to use dental provider software or office staff to send out automatic reminders via email or text message if a member has missed a follow-up visit or is past due for service. **[Quality, Timeliness, and Access]**

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

Table D-8 contains a summary of the follow-up actions that the MCE completed in response to HSAG’s CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table D-8—Follow-Up on Prior Year's Recommendations for Performance Measures

Recommendations
It was noted by **MCNA** during the review that the MY 2020 rates declined due to the COVID-19 PHE, 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 PHE, 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.
Response
Describe initiatives implemented based on recommendations: • **MCNA** has traditionally worked with the NE Provider Network diligently pre and post PHE. In regard to "optimal office hours" which may be identified as hours most conducive to schedule appointments for preventive services, the provider determines how he or she schedules appointments in their practice. However, **MCNA** does actively engage in assisting with provider operational issues, i.e., claims, pre authorizations, and credentialing on the back end to alleviate administrative burden, allowing the provider to schedule all members as their operational efficiency allows. • **MCNA** has continually monitored its rates to review access to preventive care. Pandemic rate impact has been less of a mitigating factor in 2021–2022 than is the capacity of providers to schedule the demand for services. Availability and Accessibility Surveys are conducted no less than quarterly per **MCNA** Policy 5.105NE.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Q4 2021 Appointment Availability Survey results 65.02 percent Q1 2022 Appointment Availability Survey results 70.19 percent Q2 2022 Appointment Availability Survey results 83.87 percent
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: **MCNA** negotiates enhanced fee schedules to providers in an effort to maintain open panels and increase access to care, and provide operational support to providers to reduce administrative burden and education within the **MCNA** network. **MCNA** will continue to work with our NE provider network on opportunities to have after hour and weekend appoints available for our Members.

Assessment of Compliance With Medicaid Managed Care Regulations

Results

Table D-9—Compliance With Regulations—Trended Performance for MCNA

Standard and Applicable Review Years*	Year One (2021–2022)	Year Two (2022–2023)**
Standard Number and Title	**MCNA Results**	
Standard I—Enrollment and Disenrollment	100%	100%
Standard II—Member Rights and Confidentiality	100%	
Standard III—Member Information	85%	
Standard IV—Emergency and Poststabilization Services	100%	100%
Standard V—Adequate Capacity and Availability of Services	100%	
Standard VI—Coordination and Continuity of Care	100%	
Standard VII—Coverage and Authorization of Services	82%	
Standard VIII—Provider Selection and Program Integrity	100%	94%
Standard IX—Subcontractual Relationships and Delegation	50%	100%
Standard X—Practice Guidelines	100%	100%
Standard XI—Health Information Systems	100%	100%
Standard XII—Quality Assessment and Performance Improvement	100%	100%
Standard XIII—Grievance and Appeal System	85%	

*Bold text indicates standards that HSAG reviewed during CY 2022–2023.
**Grey shading indicates standards for which no comparison results are available.

Table D-10 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 2022–2023.

Table D-10—Summary of MCNA Scores for the CY 2022–2023 Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Credentialing	100	87	86	1	13	99%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**165**	**164**	**1**	**25**	**99%**

* 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, Timeliness, and Access]**

Six out of the seven standards reviewed during CY 2022–2023 met 100 percent compliance and HSAG identified no required actions. **[Quality, Timeliness, and Access]**

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

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

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

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

MCNA achieved full compliance in the Quality Assessment and Performance Improvement standard, demonstrating that the MCE had maintained a well-developed, thorough, and continuous QAPI program. **MCNA**'s program outlined activities such as PIPs, 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, Timeliness, and Access]**

MCNA received a score of 94 percent on the Provider Selection and Program Integrity standard and 99 percent on the credentialing record reviews. While **MCNA** had policies and procedures that outlined the

process for credentialing and recredentialing, HSAG found through the sample record reviews and interview session that **MCNA** did not consistently apply a process for board certification verification. HSAG recommends that **MCNA** add clarification to applicable policies to describe when verification checks are applicable for board certification and consistently follow policy for this process. **[Quality, Timeliness, and Access]**

Additionally, during the credentialing record review, HSAG found one sample record that had a credentialing committee review date and decision date that occurred on January 28, 2021. However, the committee decision date was entered into the records and signed as January 28, 2020. During the interview, **MCNA** staff members reported that the year was documented in error and should have been entered into the records and signed as January 28, 2021. HSAG recommends that **MCNA** implement a quality check mechanism to review the credentialing and recredentialing documents to ensure record accuracy and completeness. **[Quality, Timeliness, and Access]**

Also, during the sample credentialing record review, HSAG found the following:

- Credentialing record #10 included a provider application (attestation) date of August 2, 2021, and **MCNA** credentialing staff members performed work on the application on August 12, 2021. The approval date was December 22, 2021, which was also the signature date. HSAG noted a delay of more than four months from the application date to the credentialing decision date; therefore, the credentialing time period exceeded 30 days. **[Quality, Timeliness, and Access]**

MCNA must follow its credentialing policies and procedures that comply with the requirements of the contract to ensure that **MCNA** completes processing of credentialing applications from the provider within 30 calendar days of receipt of a completed credentialing application. **[Quality, Timeliness, and Access]**

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

Table D-11 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table D-11—Follow-Up on Prior Year's Recommendations for Compliance Review

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.
Response
Describe initiatives implemented based on recommendations: **MCNA**'s Compliance team reviews all findings and recommendations and coordinates with each business owner to assure that findings are remediated. Remediated items are monitored to confirm continued compliance.

Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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, and 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.
Response
Describe initiatives implemented based on recommendations: Updates to **MCNA**'s NE member handbook to incorporate the changes and additions identified and the draft handbook in tracked changes is currently with the State for review. **MCNA** is currently undertaking development of an update Nebraska website, which will be fully compliant with all Level AA contrast requirements. Our target release date for the new website is 01/01/2023. **MCNA** continues to work on expansion of the accessibility indicators. Currently, development is underway on our system to update this information in the facility record and a provider survey is being created as the primary tool to gather the information from provider offices. The expanded accessibility indicators will be available through both the online searchable Provider Directory and printed versions of the Provider Directory.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: No known barriers to implementing the initiatives already underway.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: The Coverage and Authorization of Services letters were not updated. It was determined the medical necessity denial letters were brought down to the lowest reading level possible without changing the intent of the letter. **MCNA** updated policy 3.203NE Service Authorization Including Retrospective Reviews and Adverse Determinations as requested. The updates were approved by the QIC on 07/23/2021. The procedure to inform members of procedures that have been approved after a peer-to-peer conversation has been added to policy 3.203NE Service Authorization Including Retrospective Reviews and Adverse Determinations. The mechanism to issue NABD letters to members was deployed on 11/1/2021. **MCNA** recognizes that the denial reason codes that generate a letter were too limited and there is a current active effort to expand that list of reason codes to ensure the member is notified of the decision to deny payment for a service in whole or in part. We expect that this expansion of denial reason codes for letter generation to be completed by October 31, 2022.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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.
Response
Describe initiatives implemented based on recommendations: **MCNA** has amended its Fiserv agreement to include the required language from 42 CFR §438.230 (c)(2). This amended agreement is pending review and execution by Fiserv.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): None.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.

Recommendations
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 and 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.
Response
Describe initiatives implemented based on recommendations: Education provided to continue to follow up with other departments if needed to provide resolution utilizing email and calendar reminders.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: None.

Validation of Network Adequacy

Results

Network Capacity Analysis

Table D-12 displays the number of eligible members used to calculate the provider-to-member ratios and geographic distribution analyses for **MCNA**. For most analyses, the member population included all enrolled members. Analyses related to pediatric specialists were limited to children, defined as members 18 years of age and younger. Analyses for OB/GYN were limited to female members 15 years of age and older.

Table D-12—Statewide Population of Eligible Members for MCNA

Member Population	MCNA
Children 18 Years and Younger	194,502
Females 15 Years and Older	NA

Member Population	MCNA
All Members*	365,598

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

NA—Not applicable.

Table D-13 displays the statewide network capacity analysis results (i.e., the number of contracted providers and the ratio of contracted providers to members) for the provider categories identified in DHHS' geographic access standards for **MCNA**.

Differences in provider ratios are to be expected across provider categories, as these should vary in proportion to members' need for providers of each category. In general, lower ratios may indicate better access to providers, while higher ratios might reflect a less accessible network or more efficient care.

Table D-13—Statewide Network Capacity Analysis Results for MCNA*

	MCNA	
Provider Category	Providers	Ratio**
General Dentists	600	1:610
Oral Surgeons	14	1:26,115
Orthodontists	27	1:13,541
Periodontists	16	1:22,850
Pediadontists	56	1:3,474

* Statewide provider counts and ratios include out-of-state providers located within the distance defined in the time and distance standards from the Nebraska state border.

** In calculating the ratios, all covered members were considered except in the case of Pediadontists (pediatric dentists), where the member population was limited to members 18 years of age and younger.

Geographic Network Distribution Analysis

Table D-14 displays the percentage of members with the access to care required by geographic access standards for all applicable provider categories and urbanicities for **MCNA**.

Table D-14—Percentage of Members With Required Access to Dental Care by Provider Category and Urbanicity for MCNA*

Provider Category	Urbanicity	MCNA Percentage of Members Within Standard
General Dentists	Urban	100.0%
	Rural	>99.9%
	Frontier	100.0%

Provider Category	Urbanicity	MCNA
		Percentage of Members Within Standard
Oral Surgeons	Urban	87.0%
	Rural	62.6%
	Frontier	21.0%
Orthodontists	Urban	93.5%
	Rural	73.2%
	Frontier	84.8%
Periodontists	Urban	74.8%
	Rural	36.9%
	Frontier	0.0%
Pediadontists	Urban	99.5%
	Rural	82.7%
	Frontier	86.4%

*Red cells indicate that minimum geographic access standards were not met by **MCNA** for a specific provider category in a specific urbanicity.

Table D-15 identifies the counties where the minimum geographic access standards were not met by **MCNA** in a specific urbanicity for each applicable provider category.

Table D-15—Counties Not Meeting Standards for MCNA by Urbanicity

Provider Category	Counties Not Meeting Standard*
General Dentists	
Rural	Cherry
Oral Surgeons	
Urban	Buffalo, Dawson, Dodge, Gage, Lincoln, Madison, Platte, Scotts Bluff
Rural	Antelope, Boone, Box Butte, Butler, Cedar, Cherry, Cheyenne, Colfax, Cuming, Custer, Dawes, Furnas, Harlan, Holt, Jefferson, Keith, Knox, Merrick, Nance, Nemaha, Pawnee, Phelps, Pierce, Polk, Red Willow, Richardson, Stanton, Thayer, Valley
Frontier	Arthur, Banner, Blaine, Boyd, Brown, Chase, Deuel, Dundy, Frontier, Garden, Garfield, Grant, Hayes, Hitchcock, Hooker, Keya Paha, Kimball, Logan, Loup, McPherson, Morrill, Perkins, Rock, Sheridan, Sioux, Thomas, Wheeler
Orthodontists	
Urban	Dakota, Dawson, Gage, Lincoln, Madison, Platte

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

*Rows are only shown if at least one county did not meet the standard.

Strengths

MCNA achieved 100 percent compliance with two network access standards by urbanicity—those related to General Dentists in urban and frontier counties. **[Access]**

MCNA achieved at least 98 percent compliance with two additional network access standards by urbanicity, for General Dentists in rural counties and Pediadontists in urban counties. **[Access]**

Summary Assessment of Opportunities for Improvement and Recommendations

MCNA's greatest opportunity for improvement is to strengthen its network of Dental Specialists and Pediatric specialists across the state. **[Quality, Timeliness, and Access]**

For the provider categories for which the MCE did not meet the time/distance standard, the MCE should assess whether this is due to a lack of providers available for contracting in the area, the lack of

providers willing to contract with the MCE, the inability to identify the providers in the data, or other reasons. **[Quality, Timeliness, and Access]**

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

Table D-16 contains a summary of the follow-up actions that the MCE completed in response to HSAG's CY 2021–2022 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or validated by HSAG.

Table D-16—Follow-Up on Prior Year's Recommendations for Validation of Network Adequacy

Recommendations
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.
Response
Describe initiatives implemented based on recommendations: **MCNA** has reviewed the detailed file review results contained within the tables and subsequent sections of the NAV File Review Findings Document provided to **MCNA** by HSAG. Additionally, **MCNA** wishes to confirm the tables and documents provided have been thoroughly reviewed and **MCNA** will not be submitting any additional files or documentation.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: None.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.
Recommendations
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. • **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. • 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.
Response
Describe initiatives implemented based on recommendations: • The Network Development team will conduct an in-depth internal investigation in HSAG's key data quality findings to identify the nature of data issues regarding providers associated with more than 10 physical service location addresses.

• No initiatives have been implemented based upon HSAG recommendations regarding panel size as **MCNA** has and will continue to ensure access to dental services (waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services described in our contract with MLTC. Network providers are required to maintain an appointment system for core dental benefits and services which are in accordance with prevailing dental community standards. **MCNA** has developed and communicated to providers and member access to care and availability standards via the provider manual, provider orientation, and member handbooks. The Provider Services Department monitors provider compliance with Provider Office Access to Service and Availability Guidelines. **MCNA** does not maintain maximum provider panel size; however, **MCNA** continues to monitor wait times and appointment standards via provider surveys, grievances and complaints regarding access to care, and panel closures on a monthly basis. Monthly reports are provided to MLTC. **MCNA** negotiates enhanced fee schedules to providers in an effort to maintain open panels and increase access to care, provide operational support to providers to reduce administrative burden and education within the **MCNA** network. • Languages spoken at the individual facilities are indicated in the Provider Directory.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Not applicable.
Identify any barriers to implementing initiatives: Not applicable.
Identify strategy for continued improvement or overcoming identified barriers: Not applicable.

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 2021 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 2021 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-validated data resulting from the DAV program 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.