

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 6 QUALITY

001. SCOPE AND AUTHORITY. This chapter sets forth the requirements of the Nebraska Medicaid Managed Care Quality Strategy (~~See 480-000-10~~). This chapter also establishes the Department's expectation for each of the health plans and the dental plan (collectively referred to as plans), in effectively managing and monitoring the quality of care provided to members. In addition to abiding to all provisions in this chapter, the health plans must abide by the provisions found in 42 Code of Federal Regulations (CFR) 438, Subpart D.

001.01 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REQUIREMENT.

The contract between the Department and each plan requires the plan to have an ongoing quality assessment and performance improvement program that Medicaid must approve.

001.02 EVALUATION REQUIREMENTS. The Department, its contracted entities or designees, or the Centers for Medicare and Medicaid Services officials may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under managed care.

002. CONTINUOUS QUALITY ASSURANCE AND QUALITY IMPROVEMENT. The departments quality strategy includes continuous assessment of how well the managed care program is meeting the quality objectives, how, based on the results of the assessment activities, the Department will attempt to improve the quality of care delivered by the health plans (based on the results of the assessment activities), and how the Department reviews the effectiveness of the quality strategy and revises it accordingly.

003. SYSTEMS FOR ASSESSMENT. The Department has implemented systems for the ongoing assessment of the quality and appropriateness of care and services furnished to all Medicaid enrollees under the health plan contracts. These systems enable the Department's monitoring of data related to the access of Medicaid clients to comprehensive, cost-effective health services, including evidence-based care options that emphasize early intervention and community-based treatment and reduced rates of costly and avoidable emergency and inpatient hospital levels of care. Through the implementation of these assessment systems, the Department can monitor trends, demonstrate success and identify challenges in achieving the objectives of the Heritage Health program.

003.01 ASSESMENT. The Department assesses the quality and appropriateness of care through multiple processes that comprise a comprehensive system of oversight:

- (A) Quarterly reporting of provider accessibility analyses, timely access standards monitoring, grievances and appeals process compliance, utilization management monitoring, results of service verification monitoring, out of network referrals monitoring and case management results.
- (B) Annual reporting of Medicaid selected performance measure results and trends related to quality of care, service utilization and member and provider satisfaction.
- (C) Annual reporting of performance improvement projects data and results.
- (D) Annual, external independent reviews of the quality outcomes, timeliness of and access to, the services covered by the plan through its external quality review organization.

- (E) Annual state-staff–conducted onsite operational reviews that include validation of reports and data previously submitted by the plan and in-depth review of areas that have been identified as potentially problematic.
- (F) Medicaid requires the plan to attend annual Quality Management Committee meetings, during which data and information designed to analyze the objectives of the Quality Strategy are reviewed. The Quality Management Committee recommends actions to improve quality of care, access, utilization, and client satisfaction, and to review the results of the performance improvement projects and recommend future performance improvement projects topics. The Quality Management Committee also reviews the state’s overall Quality Strategy and makes recommendations for improvement.

003.02 OPERATIONAL ON-SITE REVIEW. Operational reviews are conducted for each health plan annually by the Department. Additionally, random reviews of each health plan notification of adverse actions will be completed. The Department and other agencies may use the operational review to validate a plan’s accreditation.

003.02(A) COMPONENTS OF THE OPERATIONAL REVIEWS. Operational reviews include, but are not limited to, an in-depth review of each health plan’s quality management work plan, review of cultural competency, general administration, and delivery system.

003.03 EXTERNAL QUALITY REVIEW. The Department is required to contract with a qualified External Quality Review Organization to perform an annual external quality review for each contracting health plan. The External Quality Review Organization is independent from the Department and from the health plans.

003.03(A) EXTERNAL QUALITY REVIEW ORGANIZATION DUTIES. The External Quality Review Organization will annually:

- (i) Validate performance improvement projects required by the Department that were underway during the preceding 12 months;
- (ii) Validate the health plans performance measures reported to the Department during the preceding 12 months; and
- (iii) Conduct a review to determine the health plans compliance with standards.

003.03(B) EXTERNAL QUALITY REVIEW ORGANIZATION RESULTS. The Department will use the results of the reviews in assessing and monitoring the quality and appropriateness of care provided to members as part of the Department’s quality strategy.

003.04 DETERMINATION OF CONTRACT COMPLIANCE. The Department will monitor the health plans contract for compliance. A plan is noncompliant if it falls below the established standards for quality of care, access, client satisfaction, utilization, and encounter submission.

003.04(A) VIOLATIONS SUBJECT TO INTERMEDIATE SANCTIONS. The following violations are grounds for intermediate sanctions that may be imposed when a health plan acts or fails to act as follows:

- (i) The health plan fails substantially to provide medically necessary services that the health plan is required to provide, under law or under its contract with the State, to an enrollee covered under the contract;
- (ii) The health plan imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

- (iii) The health plan acts to discriminate among enrollees on the basis of their health status or need for health care services;
- (iv) The health plan misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services or to the State;
- (v) The health plan misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
- (vi) The health plan fails to comply with the requirements for physician incentive plans, if applicable;
- (vii) The health plan has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information; or
- (viii) The health plan has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

003.04(B) ENFORCEMENT. The health plans that are determined to be performing below quality standards through periodic reporting, performance measures, member satisfaction surveys, encounter data submission, on-site operational review, and/or review and analysis of the quality management work plan will be required to submit a plan of correction which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Medicaid requires follow-up reporting by the health plan to assess progress in implementing the plan of correction.

003.04(B)(i) ADDITIONAL ACTIONS. If the health plan has not come into compliance upon completion of the plan of correction, the Department will take additional actions against the health plan. These additional actions include:

- (1) Instituting a restriction on the types of enrollees;
- (2) Changing the auto assignment algorithm to limit the number of enrollees into the plan, when applicable; or
- (3) Ban new auto-assignments to the plan, when applicable.

003.04(C) INTERMEDIATE SANCTIONS. The Department will impose the following sanctions for violations subject to intermediate sanctions listed in 482 NAC 6-003.04(A):

- (i) Civil monetary penalties in the following specified amounts:
 - (1) A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations;
 - (2) A maximum of \$100,000 for each determination of discrimination; or misrepresentation or false statement to the Centers for Medicare and Medicaid Services or the Department;
 - (3) A maximum of \$15,000 for each recipient the Department determines was not enrolled because of a discriminatory practice, subject to the \$100,000 overall limit;
 - (4) A maximum of \$25,000 or double the amount of the excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The Department must deduct from the penalty the amount of overcharge and return it to the affected client member.
- (ii) Appointment of temporary management as described in Section III.Y Early Termination of the health plan's contract;

- (iii) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;
- (iv) Suspension of all new enrollment, including default enrollment, after the date of the effective date of the sanction; and
- (v) Suspension of payment for members enrolled after the effective date of the sanction and until the Centers for Medicare and Medicaid Services or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to occur.

004. IMPROVEMENT. Based on the results of assessment and monitoring of quality and appropriateness of care and contract compliance, the Department will target improvement efforts.

004.01. INTERVENTIONS FOR IMPROVEMENT. The Department will utilize, but is not limited to the following interventions to improve the quality and appropriateness of care:

- (A) Quality Committee: The Department has established a Quality Committee;
- (B) Performance Improvement Projects: The health plans are required to conduct at least two clinical and one non-clinical projects annually. For each project, the Department with the Quality Management Committee will choose the topic, develop the study methodology and determine interventions to reach improvement goals. Each plan will conduct the same project, at least one will be a joint project with another plan (~~See 482-000-11~~);
- (C) Quality Performance Dashboard: In an effort to monitor a health plans performance on quality measures, a quality performance dashboard was developed. The dashboard approach provides a framework for benchmarking performance and assists health plans to prioritize quality improvement planning. The dashboard gives a multi-dimensional view of a health plans performance by comparing quality measures to national standard measures, if appropriate, to baseline measures for the program, and over two years. The dashboard results will display on the Department's website; and
- (D) Health plans sanctions ~~See 482 NAC 6-003.04(A).~~

005. QUALITY MANAGEMENT COMMITTEE. The Department has established a Quality Committee for Managed Care consisting of Department staff, Medicaid staff, Public Health staff, the health plans, providers, and other stakeholders.

006. ACCREDITATION. The ~~Heritage Health~~ health plans must have National Committee for Quality Assurance Accreditation or another national accreditation for the Medicaid Managed Care plan. The dental plan must have National Committee for Quality Assurance Accreditation or URAC accreditation. The health plans must submit a copy of the accrediting body's letter indicating the most recent accreditation status at the time of initial contracting. The **health** plans must submit any changes or updates to the Department within thirty ~~(30)~~ days of receipt.

006.01 SURVEY RESULTS. Upon survey by the accrediting body, the health plan must submit a copy of the survey results to the department within thirty ~~(30)~~ days of receipt. The health plan must submit a copy of any work plan that addresses improvements needed or follow-up necessary because of the survey. The plan must submit any changes or updates to the survey results or work plan to the Department within 30 **thirty** days of receipt.

006.02 NON-ACCREDITATION. In the event that a health plan is not accredited at the time of contracting, the health plan is required to submit to the Department, for approval, a plan to be fully accredited within the five year contracting period. The health plan must submit a work

plan including the timeline to accomplish plan accreditation to the Department. The health plan must provide a status update to Departmental staff at the time of the annual on-site operational review.

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