482-000-11 NHC Quality Strategy

Note: For purposes of this guide, the term plan is defined to mean physical health plan.

Physical Health Quality Assessment and Standards

The overall goal of the Department's Quality Strategy for Physical Health is to continuously improve the quality of care and services provided to all clients enrolled in the Nebraska Health Connection (NHC) and to identify and act upon opportunities for improvement. The NHC will promote the delivery of health care services in accordance with required access standards, standard performance measures, established benchmarks, and comparisons in order to improve quality of care provided to clients.

The objectives of the NHC's Quality Strategy (see Attachment A) are improved access to quality care, improved clients satisfaction, reducing racial and ethnic health disparities, reducing costs, and reducing/preventing unnecessary/inappropriate utilization. The Department assesses and monitors the quality and appropriateness of care delivered to clients through the collection and analyses of data from many sources.

The Department will utilize the following sources of assessments for the monitoring of the quality and appropriateness of care, access, satisfaction, and utilization:

1. Quality Of Care Reporting Requirements:
   a. Performance Measures-the following Performance Measures will be used to establish baseline data and also to be compared to national benchmark standards, if available. Data related to each of the performance measures must be submitted by June 15 of the year following the measurement year. If a measure has a performance standard already set, this standard is listed:
      i. HEDIS Comprehensive Diabetes Care
      ii. HEDIS Adult BMI Assessment
      iii. HEDIS Chlamydia Screening in Women
      iv. HEDIS Cervical Cancer Screening
      v. HEDIS Breast Cancer Screening
      vi. HEDIS Colorectal Cancer Screening
      vii. HEDIS Cholesterol Management for Patients With Cardiovascular Conditions
      viii. HEDIS Controlling High Blood Pressure
      ix. HEDIS Use of Appropriate Medications for People With Asthma
      x. HEDIS Medical Assistance With Smoking Cessation
      xi. HEDIS Prenatal and Postpartum Care
      xii. HEDIS Frequency of Ongoing Prenatal Care
      xiii. HEDIS Well Child Visits in the First 15 Months of Life
      xiv. HEDIS Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
      xv. HEDIS Adolescent Well-Care Visits
      xvi. HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
      xvii. HEDIS Lead Screening in Children
      xviii. HEDIS Childhood Immunization Status Combo 2 and Combo 3
      xix. HEDIS Childhood Immunization Status Combo 3

xx. HEDIS Race/Ethnicity Diversity of Membership
xxi. EPSDT Screening Participation Rate: 72%

b. Care Management Measures-the following measures related to case management will be used to report data and establish baseline data for determining benchmark standards related to case management. Case Management Reporting data is submitted by the MCO annually:
   i. Number and % of enrolled clients receiving the Health Risk Assessment (HRA)
   ii. Number and % of enrolled clients identified for case management
   iii. Number and % of clients receiving case management
   iv. Number and % of clients by client group (AABD, special needs, etc.) receiving case management
   v. Number and % of clients receiving case management by medical condition-overall and by age group (0-18, 19-64, 65+)
   vi. Number of % case management outcomes achieved-overall and by age group
   vii. Number and % of case management cases closed with reason for closing-overall and by client group.

c. Grievances-MCOs must report quarterly compliance with the grievance/client complaint process outlined in 482 NAC 7-002 Grievance Process. Summary data reporting must include # 34-2010of grievances filed in the reporting quarter, # of resolved grievances, timeframes for resolution, and grievance trends identified through analysis. Detailed data must be submitted for client grievances that have been unresolved for more than forty-five (45) days must be submitted. Health plans must submit data via the uniform report format to ensure that data is consistent and comparable.

d. Appeals-MCOs must report quarterly compliance with the appeal process outlined in 482 NAC 7-003 Appeal Process. Summary data reporting must include # of notice of actions issued and reasons why for the reporting quarter, # of appeals filed in the reporting quarter, # of resolved appeals and outcome of resolution, # of appeals withdrawn, timeframes for resolution, and appeal trends identified through analysis. Health plans must submit data via the uniform report format to ensure that data is consistent and comparable.
   Department staff will also track client appeals made through the State fair hearing process and compile these results with the health summary data for an annual overall composite report.

e. Service Verification Monitoring-Health plans are required to have in place a method for verifying that services were actually provided. Health plans must submit results of the service verification monitoring to the Department on a quarterly basis.

f. Provider complaints-Health plans must report quarterly data related to provider complaints. Summary data reporting must include # of provider complaints filed in the reporting quarter, # of resolved complaints, timeframes for resolution, and provider complaint trends identified through analysis. Detailed data must be submitted for provider complaints that have been unresolved for more than forty-five (45) days must be submitted. Health plans must submit data via the uniform report format to ensure that data is consistent and comparable.

g. Enrollment/Disenrollment reporting-Health plans must report quarterly summary data related to enrollment/disenrollment including disenrollment reasons other than loss of Medicaid.

2. Access Standards Reporting Requirements-Health plans must submit quarterly reports in a standardized format verifying that their provider networks meet the following access standards for managed care:

a. Timely Access-Standards for appointment availability for Primary Care Physicians (PCPs)and Specialists:

Timely Access		
Physician Type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Emergency Care	Twenty-four (24) hours per day, seven (7) days per week
	Medically Necessary Care	Same day
	Urgent Care	Two (2) calendar days
	Routine Care	Fourteen (14) calendar days
Specialists	Medically Necessary Care	Two (2) calendar days from date of referral
	Urgent Care	Three (3) calendar days from date of referral
	Routine Care	Thirty (30) calendar days from date of referral
Prenatal	First (1st) Trimester	Seven (7) calendar days
	Initial Second (2nd) Trimester	Seven (7) calendar days
	High Risk	Three (3) calendar days from date of referral

b. Timely Access-Standards for hours of operation for PCP's:

i. One (1) Medical Doctor (MD) practice-20 hours per week

ii. Two (2) or more MD practice-30 hours per week

c. Geographic Access-Standards for provider location to clients:

i. Two (2) PCP's within twenty (20) miles of residence

ii. One (1) Acute Care Hospital within thirty (30) miles of residence

iii. One (1) High Volume Specialist (i.e. Cardiologist, Neurologist, Oncologist) within sixty (60) miles of residence
iv. Provider access of more than one (1) PCP that is culturally diverse and sensitive

In addition to reporting relating to access standards, the health plans must report quarterly data related to the provider network for the plan including PCP's, Specialists, Hospitals, Urgent Care Centers, Federally Qualified Health Centers, Rural Health Clinics, and Ancillary providers. These reports must include a provider capacity report which must identify PCP's with closed panels and an accessibility analysis report for PCP's Specialists, Hospitals, and Ancillary providers.

3. Client Satisfaction Surveys-each health plan must conduct a standardized survey of clients' experience of care/satisfaction. The standardized survey is the CAHPS Health Plan Survey 4.0. In addition, the Enrollment Broker (EB) contractor conducts an independent CAHPS Health Plan Survey 4.0. Results must be submitted to the Department annually in March for the previous calendar year. The Department will compile results from each health plan and the EB into an overall composite. Results from the surveys will also allow for a health plan to health plan comparison. The results of the surveys will be made available to Medicaid beneficiaries through the DHHS managed care website to assist them in the process of selecting an appropriate health.

4. Utilization Reporting Requirements-Each health plan is required as part of its Quality Assessment and Performance Improvement (QAPI) program effective mechanisms to detect under utilization and overutilization of services. Results of utilization monitoring reports must be submitted quarterly. Reported data to detect over/under utilization must include, but is not limited to:
   a. Bed Days per 1,000
   b. Outpatient services per 1,000
   c. Unplanned re-admission within one week
   d. ER visits
   e. HEDIS frequency of procedures
   f. EPSDT visits

   The Department has also established management reports produced from encounter data that identify utilization trends/patterns.
   Additionally, each health plan must submit quarterly, the number of complaints of fraud and abuse that are made to the health plan that warrant preliminary investigation. The health plan must also submit to the Department the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through complaints, organization monitoring, contractors, providers, clients, or any other source:
   a. The name of the individual or entity that committed the fraud and abuse;
   b. The source that identified the fraud or abuse;

c. The type of provider, entity or organization that committed the fraud or abuse;
d. A description of the fraud or abuse;
e. The legal and administrative disposition of the cases, if available, including action taken by law enforcement officials to whom the case has been referred; and
f. Other data/information as determined by the Department.

The Department, Medicaid Program Integrity staff, and the health plans participate in quarterly meetings to discuss suspected and actual fraud or abuse situations and determine action to be taken and monitor actions taken until resolution.

5. Encounter Data-Each health plan is required to submit encounter data monthly to the Medicaid Management Information System (MMIS). Encounter data submitted must comply with the format provided by the Department until the MMIS is capable of accepting 837I and 837P transactions. Health plans are required to meet the submission standard of 95% error free rate meaning 95% of encounter data submitted passes all edits. If the file does not meet the 95% submission rate, the file will be rejected and returned to the plan. The plan must submit a new file within 7 business days. Reports will not be run from encounter data until the 95% submission rate is achieved.

Health plans that do not meet the 95% submission rate for 3 consecutive months will have the auto assignment algorithm changed to limit the number of clients assigned to that plan. The change will be applied to the health plan until the plan comes into compliance.

6. External Quality Review-Technical Report-The Department contracts with an External Quality Review Organization (EQRO) to prepare an EQRO Technical Report for each MCO (health plan). On an annual basis, the EQRO prepares a compendium of plan-specific descriptive data reflecting the CMS protocols for external quality reports. This analysis includes validation of performance measures, compliance with access standards, structure and operation standards, and validation of performance improvement projects. The EQRO then compiles a profile for each plan including a summary of plan strengths and weaknesses. External Quality reviews are completed annually. This report provides a concise summary of critical quality performance data for each plan as well as the EQRO's assessment of plan strengths and opportunities for improvement. Each year, the Department and the EQRO reassess each MCO's progress in addressing and improving identified problem areas.

7. Clinical Standards/Guidelines-The Department requires health plans to adopt clinical standards/guidelines that meet the following requirements:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
   b. Consider the needs of the clients enrolled in the health plan;
   c. Are adopted in consultation with contracting health care professionals; and
   d. Are reviewed and updated periodically as appropriate.

The health plans must disseminate clinical standards/guidelines to all affected providers and, upon request, to clients and potential clients. The health plan must also ensure that the decisions for utilization management, client education, coverage services, and other areas to which the standards/guidelines apply are consistent with the standards/guidelines.

8. On-site Operational Reviews-Operational reviews are conducted for each health plan annually. The review is designed to supplement other Departmental monitoring activities by focusing on those aspects of health plans performance that cannot be fully monitored from reported data or documentation.

   The on-site operational review focuses on validating reports and data previously submitted by the health plan including but not limited to client enrollment and disenrollment, processing of grievances and appeals, violations subject to intermediate sanctions, violation of the conditions for Federal Financial Participation, and other provisions of the contract as appropriate. This review is completed through a series of review techniques that include an assessment of supporting documentation, and conducting a more in-depth review of areas that have been identified as potential problems areas.

   Additionally, Departmental staff conducts random reviews of each health plan's delegated function of notifying clients of adverse actions to ensure that the health plan is notifying clients in a timely manner.

   Furthermore, the operational review is used to validate the health plan's accreditation status and to identify areas of noteworthy performance and accomplishment.

   Components of the operational review include, but are not limited to, validation of reports and data previously submitted, an in-depth review of each health plan's Quality Management Work Plan, review of cultural competency, general administration, and delivery system. A standardized format is used with each health plan to ensure data is consistent and comparable.

3. Performance Improvement Projects (PIP)-All MCOs (health plans) are required to conduct at least one (1) PIP annually using a report template that reflects the CMS requirements for a PIP. For each PIP, a topic is chosen, study methodologies developed, and the MCO conducts interventions to reach their improvement goals. PIPs are designed to improve the quality of care and service delivery and include gathering of baseline data from and other sources, designing and implementing interventions, measuring the impact of the interventions, and maintaining/sustaining that improvement.

After baseline rates for each MCO are established and interventions to improve performance have been implemented, each MCO will report study processes and results to the Department quarterly with an annual report due fifteen (15) months after the study begins. Quarterly reports and annual reports will continue until the completion of the PIP.

The topic for the Performance Improvement Project for 2011 will be determined and will include:

i. Study Topic;
ii. Study Question;
iii. Study Indicators and Goal;
iv. Study Population;
v. Data Collection;
vi. Evaluation of findings from data collected;
vii. Intervention and Improvement Strategies;
viii. Data Analysis and Interpretation of Study Results;
ix. Plan for Real Improvement; and
x. Achieve Sustained Improvement.

Results of the PIP's are presented to the Quality Committee to determine if sustained improvement has been achieved. In addition, analyzing the results of the PIP's, the Quality Committee will choose the topic for the next PIP, study methodologies, and recommend improvement goals and interventions to achieve improvement goals. The chosen topic is based on an identified area requiring improvement.

4. ACCreditation-Managed Care Organizations(MCOs) and Managed Care Entities, (MCEs) (any risk bearing reimbursement strategy) must be accredited by the National Committee for Quality Assurance(NQCA) or other national certification for the Health Plan's Medicaid Managed Care Product line. The Health Plan is required to submit verification of the accreditation status to the Department as follows:

   i. An unabridged copy of the accrediting body's letter indicating the most recent accreditation status. (Any changes or updates are to be sent in unabridged form to the State within 30 days of receipt);
   ii. An unabridged copy of the survey results. (Any changes or updates are to be sent in unabridged form to the Department within 30 days of receipt); and
   iii. An unabridged copy of the Health Plan's work plan that addresses any improvements needed or follow-up necessary as a result of the survey. (Any changes or updates are to be sent in unabridged form to the Department 30 days of receipt).

5. Provider Credentialing/Re-credentialing-The Health Plans are required to manage a credentialing, re-credentialing, recertification, or performance appraisal process for contracted Network and out of Network providers. This process must take into consideration data such Nebraska Medicaid client complaints, results of quality reviews, utilization review/management information, and client satisfaction surveys. The MCO Health Plans are required to verify provider qualifications in accordance with all state licensing standards, accreditation standards, Medicaid/Medicare Sanction databases, and any other State and Federal standards. The MCO Health Plans is are required to obtain/verify the following (but not limited to) information:

i. Current Medicaid-enrolled status;
ii. Current valid license to practice;
iii. Current ownership and disclosure information in accordance with 42CFR 455.104, 455.105 and 455.106;
iv. Search names of provider/disclosed individuals against the HHS-OIG list of Excluded Individuals/Entities(LEIE), General Services Administration (GSA) and Excluded Parties List (EPLS);
v. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
vi. Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS);
vii. Education, training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training;
viii. Board certification if the practitioner states s/he is board certified on the application;
ix. Current, adequate malpractice insurance meeting the Health Plan's requirements;
x. History of professional liability claims that resulted in settlements or judgments by or on behalf of the practitioner (may be obtained by the National Practitioner Data Bank); and
xi. Information about sanctions or limitations on licensure from the applicable state licensing agency or board;

The Department will monitor this process through on-site reviews, external quality audits and other data sources. The Health Plan must determine and re-determine every three years compliance with all of the above and accreditation standards and Medicaid requirements. The MCO Health Plans are required to report to the Department when a practitioner's or provider's affiliation is suspended or terminated because of quality deficiencies. This must be reported to the Department in the quarter in which it occurs.

Attachment A – Quality Strategy for the Nebraska Department of Health and Human Services Medicaid Managed Care Program

Insert Quality Strategy Here