Division of Medicaid and Long-Term Care
Heritage Health Quarterly Report, January-March 2018

June 26, 2018

Prepared for the
Health and Human Services Committee
of the Nebraska Legislature

Senator Merv Riepe
Chairman, Health and Human Services Committee
Room #1402
P.O. Box 94604
Lincoln, NE 68509

Dear Chairman Riepe and Members of the Health and Human Services Committee:

We are pleased to submit for your review the FY18 3rd Quarter report on Heritage Health, Nebraska's Medicaid managed care program. This report is organized into four sections: business performance; stakeholder engagement; quality management and performance improvement; and the future, a roadmap of Medicaid and Long-Term Care's (MLTC) path forward.

While business performance is certainly an important part of MLTC's management oversight of the Heritage Health program, it represents only one side of the evaluative equation. The Triple Aim is a widely recognized approach to optimizing health system performance created by the Institute for Healthcare Improvement. It is a framework developed around the belief that new designs must be developed to pursue three dimensions of performance: 1) improving the patient experience of care (including quality and satisfaction); 2) improving the health of populations; and 3) reducing the per capita cost of health care (IHI, 2018).

The objectives of The Triple Aim and managed care are aligned in the marketplace and allow for an evaluative shift beyond business performance to a broader quantification of value focused on cost, quality, and satisfaction with outcomes assessed at both the individual level and across populations. The formalization of the Health Management Program organizes MLTC resources to enhance, expand, or add to our clinical, statistical, economic, and ethical evaluative capabilities; provide a mechanism for improved collaboration and coordination with internal and external stakeholders to best achieve The Triple Aim, foster market innovations, and drive performance improvement; and position MLTC to share our knowledge and accomplishments through publication.

I thank the committee for your support and interest in the work of MLTC and the endeavors of Heritage Health. Together we can accomplish much as we collectively strive to better our abilities and refine our services, for the good of those we serve.

My regards,

Matthew A. Van Patton, DHA
Director, Division of Medicaid and Long-Term Care

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I. BUSINESS PERFORMANCE

MLTC closely monitors the performance of each of the three Managed Care Organizations (MCOs) in Heritage Health. The MCOs are currently putting into use a new biweekly dashboard for reporting important performance data, which will become increasingly useful in assessing performance trends over time.

This new dashboard was launched in the spring of 2018. As such, the data included below will reflect similar metrics, but was pulled from existing reports between January and March 2018. A template copy of the MCOs' new biweekly dashboard is available in the appendix.

The following tables detail totals by plan, by quarterly total or by month, between January and March 2018. The following acronyms are used for each health plan:

- Nebraska Total Care- NTC;
- UnitedHealthcare Community Plan of Nebraska- UHCCP; and
- WellCare of Nebraska- WHP.

Provider Network

Figure 1: New Contracts

	January	February	March
NTC	18	11	7
UHCCP	4	19	2
WHP	19	15	11

The plans' networks are always evolving. New contracts from this quarter represent contracts signed, rather than the number of individual providers added. Contracts may include a number of providers.

Figure 2: Providers Terminated

	January	February	March
NTC	4	14	16
UHCCP	59	40	48
WHP	15	11	9

It is not uncommon for providers to leave networks for various reasons. The top trending reasons for this quarter include: the provider left the practice, retirement, and voluntary removal from the network.

Claims

Figure 3: Number of Claims Received

	January	February	March
NTC	379,093	356,301	385,774
UHCCP	329,059	311,111	335,872
WHP	202,276	192,137	206,962

This information is representative of the volume of claims for the member mix of each health plan on a monthly basis.

Figure 4: Number of Claims Adjudicated

	January	February	March
NTC	465,662	413,910	455,670
UHCCP	321,468	311,055	339,071
WHP	192,279	191,674	215,389

This data set shows all claims that were successfully entered into the health plans' billing systems. After a claim is entered into the system, the plans are able to either pay or deny the claim.

It is not uncommon for the MCOs to adjudicate more claims than they received in a given month because the adjudication number includes re-processed claims. Claims can be re-processed for a variety of reasons, including retroactive rate changes.

Figure 5: Percentage of Claims Rejected

	January	February	March
NTC	2.63%	2.99%	2.21%
UHCCP	0.65%	0.52%	0.33%
WHP	3.55%	3.72%	3.55%

Rejected claims are claims that do not meet basic legibility, format, or completion requirements and therefore are not received into the MCO's system for adjudication. Common reasons for rejected claims include clerical errors and missing information.

Figure 6: Percentage of Claims Denied

	January	February	March
NTC	16.44%	15.49%	13.79%
UHCCP	18.35%	19.58%	19.08%
WHP	18.18%	16.74%	16.01%

A clean claim can be adjudicated and denied by the MCO for various reasons. The denial reasons are submitted by each plan on a monthly basis and separated out into behavioral health claims and physical health claims, with the top 10 reasons specified for both. Trending denial reasons include: duplicate claims, need to bill primary insurance, service not covered by Medicaid, and member not eligible at time of service.

Figure 7: Claims Dollars Paid, Non-Pharmacy

	FY18 Q3
NTC	$ 73,991,206
UHCCP	$ 60,890,470
WHP	$ 61,323,526

This spend is reflective of the population assigned to each health plan and shows the volume of claims being paid out to providers on a month over month basis.

Figure 8: Claims Dollars Paid, Pharmacy

	FY18 Q3
NTC	$ 24,777,188
UHCCP	$ 24,523,732
WHP	$ 13,359,963

Processing for pharmacy claims is unique in that pharmacy operates as a ‘point of sale’ system, whereas the claims for medical and behavioral health are filed after the provider has seen the member.

Figure 9: Percentage of Claims Adjudicated Within 10 Days

	January	February	March
NTC	99.16%	99.09%	99.58%
UHCCP	99.06%	98.70%	96.90%
WHP	98.93%	97.56%	97.41%

The health plans are required to process their claims in a timely manner, and MLTC monitors the progress through reporting. Per their contracts, 90% of claims must be adjudicated within 15 business days; the Quality Payment Program threshold is 95% within 10 business days (for physical and behavioral health claims).

Figure 10: Percentage of Claims Adjudicated Over 60 Days

	January	February	March
NTC	0.39%	0.20%	0.12%
UHCCP	0.02%	0.01%	1.74%
WHP	0.05%	0.01%	0.02%

The plans are contractually required to adjudicate all claims within 60 days. Any claims paid over 60 days are subject to being paid with interest.

Care Management

Active engagement with patients and their families helps patients successfully navigate the continuum of care to achieve better health outcomes, improve experiences, and reduce the cost of health care, otherwise known as The Triple Aim.

Each plan is able to identify for itself which of its members are in high, medium, and low-level care per MLTC guidelines. Due to this, the statistics vary between plans.

Figure 11: Members in High-Level Care

	January	February	March
NTC	42	31	32
UHCCP	1,077	1,175	1,321
WHP	50	48	40

Figure 12: Members in Medium-Level Care

	January	February	March
NTC	36	20	41
UHCCP	8,111	8,146	8,003
WHP	38	40	38

Figure 13: Members in Low-Level Care

	January	February	March
NTC	182	163	187
UHCCP	70	73	81
WHP	47	44	42

Pharmacy

MLTC is monitoring the pharmacy spend through Heritage Health and will be working with stakeholders to identify strategies which address increasing costs. MLTC is involved in the national conversation around increasing pharmacy costs, and is committed to ensuring an effective and efficient delivery of the pharmacy benefit.

Figure 14: Percentage of Generic Drugs Dispensed

	January	February	March
NTC	83.89%	84.71%	84.72%
UHCCP	85.53%	84.92%	86.12%
WHP	85.21%	85.02%	86.28%

The use of generic drugs may reduce spending and increase cost-savings in the Heritage Health program, as generic prescription drugs are typically less expensive than brand name drugs.

Figure 15: Preferred Drug List (PDL) Compliance

	FY18 Q3
NTC	96.99%
UHCCP	96.53%
WHP	97.86%

Through the Pharmacy and Therapeutics Committee, MLTC creates and manages a preferred drug list (PDL). The importance of the PDL lies in the professional review of each drug for safety, efficacy, and cost savings.

While most generics are priced lower than brand names, expenditure can be reduced even further with drug manufacturer supplemental rebates. This makes the brand name more cost-effective than the generic.

II. STAKEHOLDER ENGAGEMENT

Maps of Engagement Events

Engagement between the MCOs and both health care providers and plan members is an essential part of making Heritage Health a success. These events bring additional value to members and providers and serve as important arenas for feedback that can lead to program improvements. The following maps detail the locations of various provider and member engagement events by each MCO throughout the state in the first three months of 2018. These events include provider orientation sessions, community baby showers, and health fairs.

Figure 16: UnitedHealthcare Community Plan's FY18 Q3 Community Connections:

Figure 17: Nebraska Total Care’s FY18 Q3 Community Connections:

Figure 18: WellCare of Nebraska's FY18 Q3 Community Connections:

Case Studies from each Plan

MCO member stories

Each of the three health plans in Heritage Health submitted the following stories to highlight some of their recent member and provider outreach efforts.

UnitedHealthcare Community Plan:

For the third year in a row, UHCCP employees volunteered at the health screenings that were held in conjunction with the Special Olympics Nebraska Summer Games. The volunteers assisted over 200 athletes at check-in stations, escorted athletes to the different screenings and supported athletes in making a healthy snack on our blender bikes. More than 50 UHCCP employees have volunteered approximately 250 hours at Healthy Athletes during the past three Summer Games. The purpose of the Healthy Athletes program is to provide year-round sports training and athletic competition in a variety of Olympic-type sports for children and adults with intellectual disabilities. The goal is to improve the health and fitness of Special Olympics athletes and their ability to participate in competitions, some of which receive services from the Department of Health and Human Services.

The Healthy Athletes Program also aims to improve access to care, make appropriate referrals for follow up, train students and current health care professionals on the specific needs of individuals with intellectual disabilities, collect and analyze data, and advocate for improved policies and health programs. The current screenings offered in Nebraska include Opening Eyes, Special Smiles, FUNFitness, Healthy Hearing, Health Promotion, MedFest, Strong Minds and Fit Feet.

The health plan participation enables staff to educate and empowers members and eligible individuals about the importance of preventive health care and disease management. It is an important step to better health and access to care.

Nebraska Total Care:

Last October, NTC reached out to initiate a partnership with Habitat for Humanity of Omaha, an organization that builds affordable homes and provides supportive education for families in need. NTC presents each new Habitat home-owner with a handwritten card and a Walmart gift card at their home dedication ceremony. Thus far, NTC has celebrated 22 families, and will continue to do so for the 45 total families who will receive new homes over the course of this year. Because NTC recognizes that quality healthcare is best delivered locally, NTC strives to keep community engagement local as well. By visiting the neighborhoods in which NTC members live and work, NTC is able to truly connect with them, one person at a time.

WellCare of Nebraska:

On Thursday, May 31st, WHP partnered with Food Bank for the Heartland and Bright Futures, Kearney to hold their first 'Mini Farmers Market' of the season. The culmination of months of planning and two days of set up was a very successful event! 121 families (including 31 WHP members, 434 individual household members) received a week's worth of healthy food and produce to keep them fed during the summer months. Participants also received WHP reusable grocery bags, healthy eating tips and recipes, and a WellCare water bottle to remind them of the importance of staying hydrated. Volunteers from Mid-Nebraska Community Action, Bright Futures and a local Boy Scout troop assisted with escorting participants to their cars, loading up people's bags and so much more! Everyone that came through the pantry line was so genuinely thankful for the food and loved the personalized service they received. Tom Jochum, Principal, Bright Futures, stopped by to check things out and was so impressed that he wants to discuss a fall event where his family members (many of whom are farmers) will add their fall harvest to the mix (more to come as that evolves). The second WHP Farmers Market took place in Scottsbluff on June 21st.

MCO provider stories

WHP submitted a letter from a provider at Cirrus House that they were interested in sharing with the committee. It is available under appendix, attachment 3.

Provider survey

In an effort to improve MLTC's engagement with Heritage Health providers, efforts are taking place to standardize the yearly provider survey distributed by the MCOs to the providers. A standardized survey will allow MLTC to draw more accurate comparisons of provider experiences among the three health plans. The standardized survey tool is anticipated to be in place by calendar year 2019. The 2018 survey will be implemented under the existing arrangement whereby each MCO constructs their own provider survey per MLTC guidelines.

III. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

External Quality Review

MLTC has partnered with Island Peer Review Organization, Inc. (IPRO) to perform a federally required yearly quality review conducted by an external quality review organization (EQRO). IPRO's evaluation of Heritage Health's 2017 performance was finalized on March 30, 2018, and these findings will be posted publicly by July 1, 2018. The table below presents a high-level summary of IPRO's findings from their aggregate report of all three health plans.

Figure 19: Summary of 2017 Compliance Review Findings

Compliance Domain	NTC	UHCCP	WHP	Performance Domain(s)
Care Management	Substantial Compliance	Substantial Compliance	Substantial Compliance	Access
Provider Network	Substantial Compliance	Full Compliance	Substantial Compliance	Access
Subcontracting	Minimal Compliance	Full Compliance	Minimal Compliance	Quality
Member Services and Education	Substantial Compliance	Full Compliance	Substantial Compliance	Quality
Quality Management	Substantial Compliance	Full Compliance	Substantial Compliance	Quality
Utilization Management	Substantial Compliance	Substantial Compliance	Substantial Compliance	Quality and Timeliness
Grievances and Appeals	Substantial Compliance	Substantial Compliance	Substantial Compliance	Quality and Timeliness

For the two MCOs that were found to be minimally compliant in the subcontracting category, a plan to correct the deficiency was submitted to MLTC and will be reviewed to ensure the MCO has come into compliance with the standards.

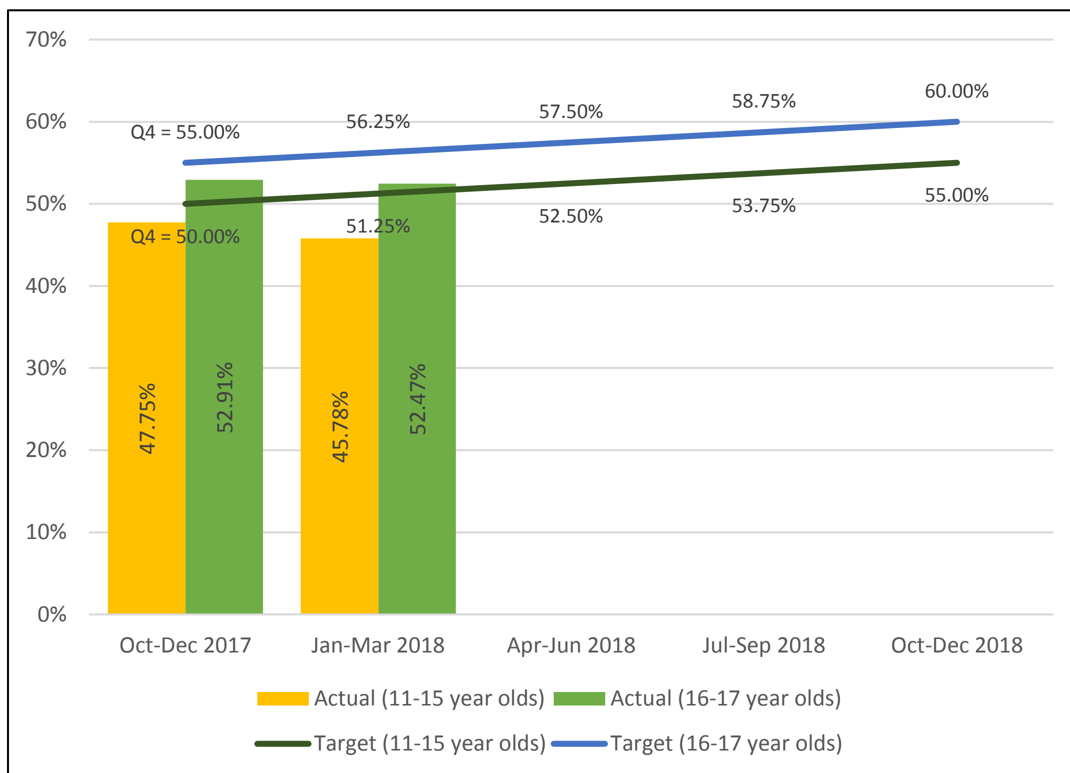
The evaluations of each MCO were performed between Jan. 1 and Aug. 31, 2017. Definitions of each compliance domain and levels of compliance from the external quality review (EQR) are available in appendix, attachment 4.

Dashboard Metrics

The 800+ reporting requirements included in each MCO's contract with the State of Nebraska allow for highly measureable results and outcomes from the Heritage Health program. The following information includes highlights of some of the health outcomes from Heritage Health. These metrics were developed in consultation with the MLTC medical director, Dr. Lisa White. This information is tracked in the Department of Health and Human Services Dashboard.

The objective of the treatments being measured is to promote better health outcomes in a manner that is both clinically and cost effective.

Figure 20: Tdap Immunization Rates for Adolescents



Here, we note the number of adolescents who have received a Tetanus, Diphtheria, and Pertussis (Tdap) immunization prior to their 18th birthday, split into two age categories: children ages 11-15, and those ages 16 and 17. This is an administrative measure looking at Medicaid claim data.

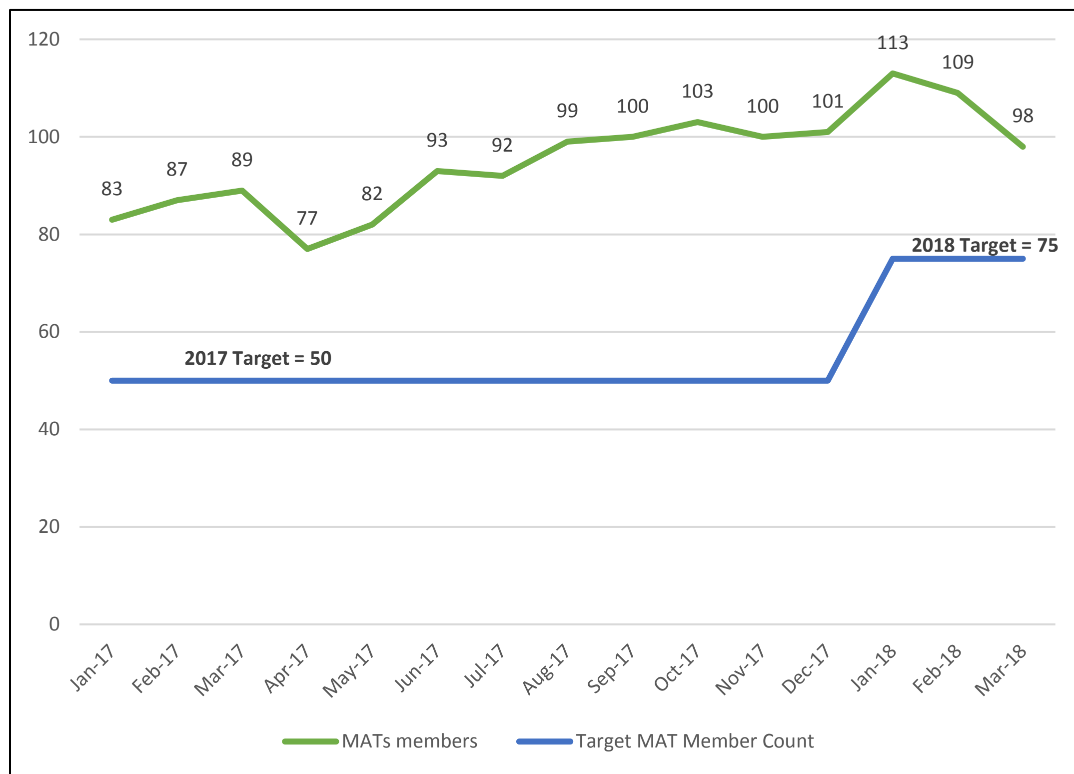
These rates may be affected due to missing data where members receive vaccinations outside of the Medicaid program. MLTC knows more adolescents may have the Tdap vaccine, but this metric is the most consistent way to measure immunization rates without performing chart audits.

America's health ranking data showed that Nebraska ranked 34th in the nation for Tdap vaccinations in 2017 – 86.8% of adolescents aged 13-17 years have had the Tdap vaccine.

In 2017, Nebraska had 27.2 cases of pertussis per 100,000 population. MLTC is working with the plans on a Tdap performance improvement project (PIP) for calendar year 2018.

Efforts are underway by each of the MCOs to improve these statistics. For example, Nebraska Total Care sends out reminder mailers to schedule well-child exams before children reach 1 year of age; Tdap vaccinations are one of the many preventative measures that can be taken at such a young age.

Figure 21: Number of Individuals Receiving Medication-Assisted Treatment



This chart depicts the count of members receiving medication-assisted treatment-related drug prescriptions from Nebraska Medicaid, by month. MLTC has exceeded its target for this measure since the beginning of Heritage Health in January 2017. Medication-assisted treatment (MAT), defined by the Substance Abuse and Mental Health Administration, is the use of a combination of behavioral therapy and medication to treat substance use disorders. A successful MAT program is one component in fighting the national opioid crisis, although MAT can also be used to treat alcoholism and tobacco addiction.

WHP has reported that successful case management of patients with a history of substance use disorder can lead to avoiding the intensity of MAT. However, with severity of the national opioid crisis, MAT will continue to be a valuable resource available to the most vulnerable Heritage Health members.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are collaborative projects between MLTC Medical Director Dr. White, the MCOs, and the EQRO aimed at improving the health outcomes of Nebraska Medicaid's beneficiaries. MLTC currently has three PIPs in place:

1. Tracking follow-up visits after emergency department (ED) visits for mental illness or alcohol or drug dependency;
2. Monitoring Tdap immunization rates in pregnant women; and
3. Monitoring 17p injection rates in pregnant women.

MLTC is currently developing or has in place overall target goals for these three projects to achieve by January 2020. A goal for ED follow-up is currently being developed, as 2017 was the first full year that HEDIS data was available for these measurements. With Tdap immunizations, MLTC is aiming for 85% and 75% for indicators 1 and 2, respectively. Finally, MLTC is aiming for a 35% 17p injection rate.

It is important to note that target rates differ among the health plans due to their unique populations and varying baseline rates. Included below is the most recent aggregate data available for each of the three PIPs:

1. Follow-up visits after ED visits
   a. Figure 22: Follow-up to ED for Mental Illness

	7 Day Follow-Up Rate	30 Day Follow-Up Rate
Q1 to Q3 2017	29.37%	52.47%

By 2020, UHCCP is aiming to increase both of their figures to 79.8%. NTC is currently aiming to improve their 7-day rate to 65% and their 30-day rate to 87.5%, both by the end of 2019. WHP is currently aiming to increase their 7-day rate to 41.8% and 30-day to 66.5%.

b. Figure 23: Follow-up to ED for Alcohol or Drug Dependency

		7 Day Follow-Up Rate	30 Day Follow-Up Rate
Q1 to Q3 2017	13 to 17 Years	5.41%	13.51%
	18 Years and Over	5.26%	9.26%
	Total	5.28%	9.76%

By 2020, UHCCP is aiming to increase their 7-day figures to 30.4% and their 30-day figures to 33.2%. NTC is aiming to improve their 7-day rate to 19.62% and their 30-day to 25.73%, both by the end of 2019. WellCare is aiming to increase their 7-day rate to 18.2% for ages 18 and older and 16.4% for ages 13 to 17. They are seeking to improve their 30-day rates to 21.2% and 25.04%, respectively.

2. Figure 24: Monitoring Tdap Immunization Rates in Pregnant Women

			Rate
Q1 to Q3 2017	Continuously eligible for Medicaid	Indicator 1	60.89%
		Indicator 2	49.45%
	Not Continuously eligible for Medicaid	Indicator 1	58.05%
		Indicator 2	46.08%

Indicator 1 refers to mothers who received the service at any point in their pregnancies. Indicator 2 refers to mothers who received the service between weeks 27 and 36 of their pregnancies, when the immunization is most effective.

UHCCP is aiming to improve their figures for group 1 to 85% and group 2 to 75%. NTC is currently aiming for 65% for group 1 and 58% for group 2. WHP is seeking to improve their rates to 79.1% for group 1 and 15.95% for group 2.

3. Figure 25: Monitoring 17p Injection Rates in Pregnant Women

			Rate
Q1 to Q3 2017	Continuously eligible for Medicaid	Indicator 1	21.34%
		Indicator 2	25.69%
	Not Continuously eligible for Medicaid	Indicator 1	19.08%
		Indicator 2	23.67%

Indicator 1 refers to mothers who received the service between weeks 16 and 26 of their pregnancies, when the injection is most effective. Indicator 2 refers to mothers who received the service at any point in their pregnancies. These injections help in preventing premature births.

UHCCP is aiming to increase their figures to 22.7% for both indicators. NTC is currently aiming for 35% for both indicators by 2020. WHP's current goal is 29.5% for both groups.

IV. FUTURE ROADMAP

Strategic Vision

The last year and a half has seen a great deal of change for the Nebraska Medicaid program. Medicaid in Nebraska is now on a newly charted course in managed care. A Medicaid managed care system, more so than a fee-for-service system, is designed and organized to manage cost, utilization, and quality of health care services.

The ongoing strategic vision of MLTC will be driven by managed care's strengths. The ability to manage cost, utilization, and quality today is key to balancing the interests of all stakeholders in the Nebraska Medicaid program, from beneficiaries and providers to the taxpayers who financially support the program.

The fulfillment of MLTC's strategic vision will be enhanced by informatics systems, both current and in development, which have the ability to collect and utilize the large volumes of data created by Heritage Health and other Medicaid programs on a daily basis. This data can be used to guide and manage the cost, utilization, and quality of services available through the Medicaid program.

Strong leadership will be essential to carrying out this strategic vision. Currently, MLTC is recruiting a new deputy director for Health Informatics and Business Integration who will be instrumental in the development of new informatics systems to continue to modernize the division.

MLTC's Two Sides of Ongoing Function

The current operational infrastructure at MLTC is focused on business performance: contract management, regulatory compliance, finance, and remaining fee-for-service program management.

As MLTC has transitioned primarily into managed care, it is more important than ever to build an enterprise that makes it possible to quantify the value of dollars spent in real economic terms- terms that define the value proposition assessed in both cost and consequences. These evaluations are key to the other side of MLTC ongoing function: outcome management.

Health Management Program

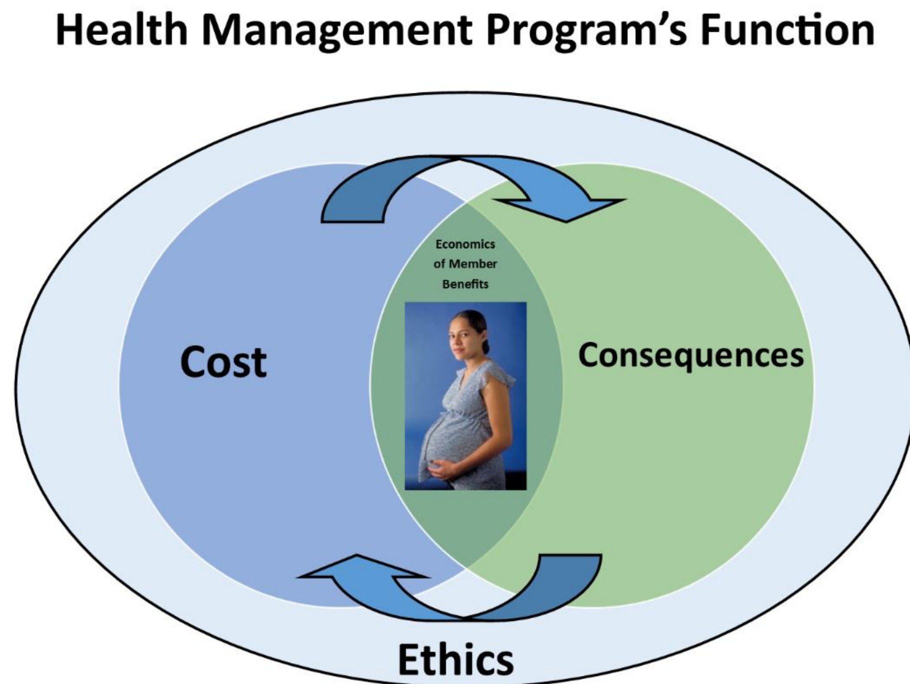
The objective of the Health Management Program, established under the direction of Dr. White, is to create a management and intelligence infrastructure for quantifying the value of managed care coordination activities within the patient populations identified and managed by the MCOs.

By fulfilling this objective, MLTC is better able to deliver on its Triple Aim for Heritage Health members. The Triple Aim seeks to improve the patient's care experience, improve the patient's health, and reduce the per capita cost of health care.

This new infrastructure will fulfill several important functions, specifically, enhanced:

1. Clinical, statistical, economic and ethical evaluation capabilities;
2. Mechanisms for improved collaboration and coordination to better fulfill The Triple Aim, foster market innovations, and drive performance improvement; and
3. Publication of information to share our knowledge and accomplishments with the marketplace.

Figure 26:



This figure illustrates how the cost and consequence of every action and decision MLTC makes within the Health Management Program impacts beneficiaries. A full economic evaluation requires the identification, measurement, and valuation of both cost and consequence, in terms of both the benefit of taking an action and the effectiveness of taking said action. For example, forgoing a less expensive medical treatment (cost) could lead to negative health outcomes (consequence) that would require a more expensive medical treatment (cost). Ethics come into play when evaluating either side of this dichotomy.

Within this program, and through active stakeholder engagement, MLTC and the MCOs will ensure that chosen health care services have benefits that outweigh their opportunity cost, or the most beneficial activities are chosen within the resources available. This decision-making process is known as the economics of member benefits.

When working inside the framework of the Health Management Program, a full economic evaluation is the only type of economic analysis that provides fully valid information. Noted here are the four health economic evaluation methodologies:

- **Cost-Benefit Analysis:** An economic evaluation in which all costs are expressed in the same units (usually money) to determine allocative efficiency (e.g. performing a comparison of costs and benefits across programs serving different patient groups).
- **Cost-Utility Analysis:** An economic evaluation in which interventions which produce different consequences, in terms of both quantity and quality of life, are expressed as utilities. Competing interventions are then compared in terms of cost per utility (a commonly used utility in this type of analysis is quality adjusted life year, or QALY).
- **Cost-Effectiveness Analysis:** An economic evaluation in which the costs and consequences of alternative interventions are expressed in cost per unit of health outcome (e.g. performing a comparison of costs and consequences of competing interventions for a given patient group within a given budget).
- **Cost-Minimization Analysis:** An economic evaluation in which consequences of competing interventions are the same and in which only inputs—that is, cost—are taken into consideration. The aim is to decide the least costly way of achieving the same outcome.

The DMA Tool

A central component to the new intelligence infrastructure MLTC is developing will be the Data Management and Analytics (DMA) tool. This tool, currently in the design build phase, will assist with coordinating and putting into use the vast amounts of data generated by Heritage Health and other MLTC programs. The tool's capabilities will be enriched by the collaborative contributions of MLTC, the MCOs, and the Nebraska Health Information Initiative (NeHII).

MLTC contracted with Deloitte Consulting, LLP, to assist with the development of the tool. The DMA is expected to launch in June 2019.

Summation

In conclusion, the infrastructure being built at MLTC will take Nebraska Medicaid well beyond the capabilities of traditional Medicaid managed care. With the improved utilization of larger amounts of data, MLTC will be able to pursue initiatives focused on enhancing care for populations, aligning payment incentives with performance goals, and building in accountability for high quality care across the entire continuum of care.

To be clear, MLTC is not building a program for firm administrative direction of the MCOs in the marketplace. Rather, through this intelligence infrastructure and other initiatives, MLTC is setting a programmatic direction by which we evaluate, collaborate, and coordinate to best achieve the broad principles of The Triple Aim: reduced cost, give better care, and create better patient and provider experiences.

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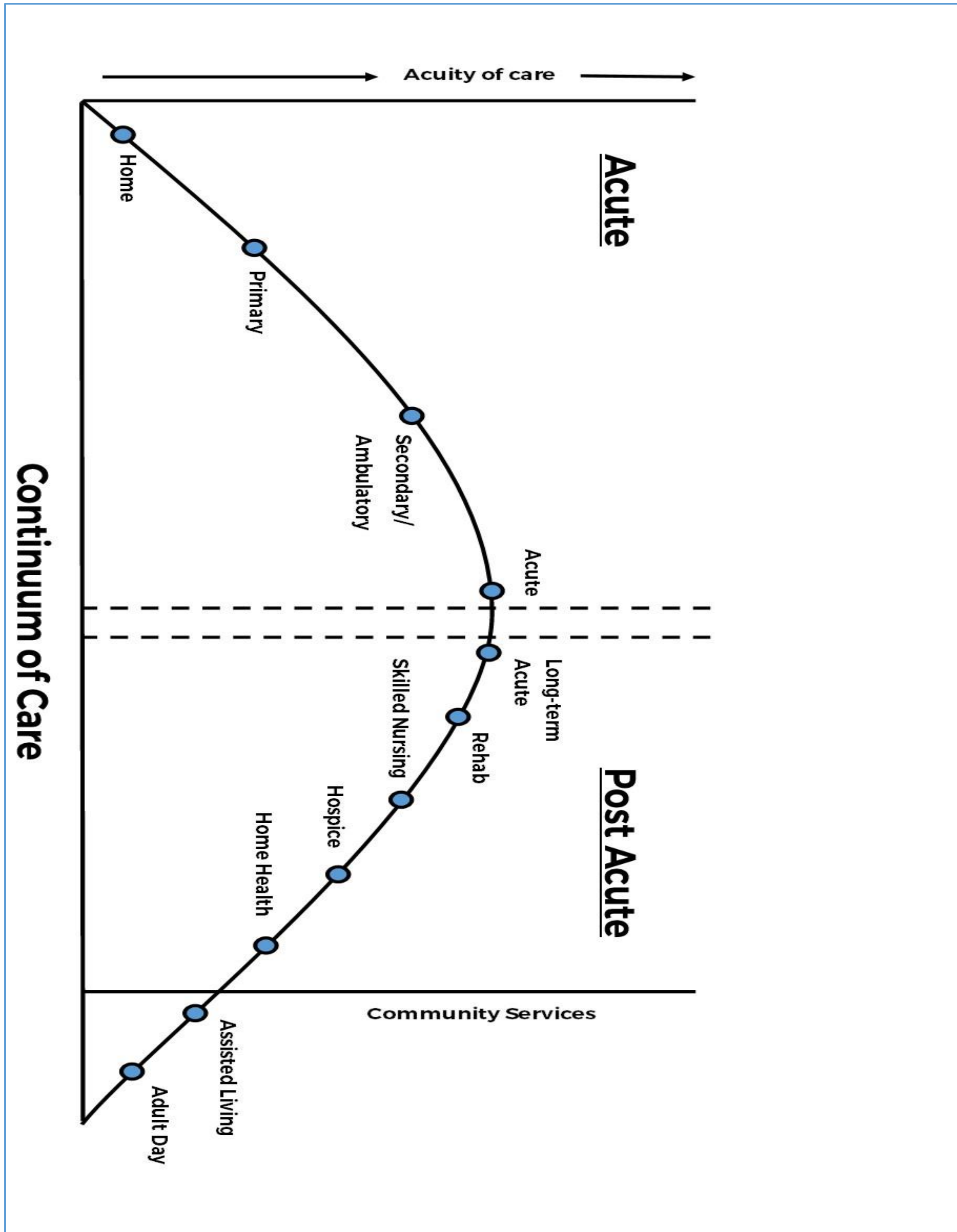
Attachment 1: Continuum of Care Graphic



Attachment 2: Heritage Health Proposed Biweekly Dashboard

The following is an in-progress data reporting dashboard which the MCOs will submit to the Medicaid director on a biweekly basis. This version was last modified on 4/20/18.

Area	Measure	QPP Std	Contract Std	Health Plan Std	Jan	Feb	Mar	YTD
Member Engagement	*Member Call Volume							
	*Abandonment Rate							
	*Average hold time (seconds)							
	Community Outreach / Member Events							
	Member Materials / Campaigns							
Provider Engagement	*Provider Call Volume							
	*Abandonment Rate							
	*Average hold time (seconds)							
	Provider Bulletins Posted							
	Webinars Conducted							
	New Provider Orientations Conducted/Provider Visits							
Provider Network	New Providers contracts							
	*Providers termed from network							
*Claims	Number of claims received							
	Number of claims processed							
	Claims Paid $ (Med / BH)							
	Claims Paid $ (Rx)							
	Percentage of claim rejects (Med / BH)							
	*Percentage of claim denials (Med / BH)							
	Turnaround time 10 day (Med/BH)							
	Turnaround time 60 day (Med/BH)							
Care Management	Members in High Level Care Management							
	Members in Medium Level Care Management							
	Members in Low Level Care Management							
	Face to Face visits							
	% of Deliveries with "notice of pregnancy" rate							
	Care Management Meetings with Partners							
Pharmacy	Percentage of Generic Drugs dispensed							
	PDL Compliance							
Quality	*New member Grievances received (Complaints)							
	% of Members Appeals Resolved within 20 calendar days							

	Lead Screening in Children							
	Tdap Immunization rate for adolescents							
	Tdap Immunization rate for pregnant women							
	Well child visits within first 15 months							
	Childhood Immunization-Combo 2							
	Childhood Immunization-Combo 10							
	17P- Compliance							
Utilization Management (Med/BH)	Total authorization requests							
	*Authorization denial rate							
	*ED Visits / 1000							
	*IP Admissions / 1000							
Finance	Revenue PMPM $							
	Medical and Behavioral Health Expense PMPM $							
	Pharmacy Expense PMPM							

Topics be expanded upon in narrative

* Provide Narrative if anomaly in data

Footnote any data field where the data is not available; Provide explanation as to why the data is not available.

Definitions:

Area	Measure	Definition	Field from existing report
Member Engagement	*Member Call Volume	Count of all calls received over the reporting period (month and YTD); provide additional detail in narrative if anomaly is identified in the data.	Member Call Center Stats; Total Calls
	*Abandonment Rate	Percent (%) of calls abandoned over the reporting period (month and YTD); provide additional detail in narrative if anomaly is identified in the data.	Member Call Center Stats; Calls Abandoned
	*Average hold time (seconds)	Average call hold time over reporting period (month and YTD), reported in seconds; provide additional detail in narrative if anomaly is identified in the data.	Member Call Center Stats; Average Hold Time
	Community Outreach / Member Events	Count of community outreach and/or member events over reporting period (month and YTD); Narrative to report detail of events since previous bi-weekly (i.e. last two week)	N/A
	Member Materials / Campaigns	Count of member materials distributed and/or focused campaigns distributed to members over the reporting period (month and YTD); Narrative to report detail of events since previous bi-weekly (i.e. last two week)	N/A

Provider Engagement	*Provider Call Volume	Count of all call received over the reporting period (month and YTD); does not include Pharmacy help desk calls; provide additional detail in narrative if anomaly is identified in the data.	Provider Call Center Stats; Total Calls
	*Abandonment Rate	Percent (%) of all call abandoned over the reporting period (months and YTD); provide additional detail in narrative if anomaly is identified in the data.	Provider Call Center Stats; Calls Abandoned
	*Average hold time (seconds)	Average call hold time over reporting period (month and YTD), reported in seconds; provide additional detail in narrative if anomaly is identified in the data.	Provider Call Center Stats; Average Hold Time
	Provider Bulletins Posted	Count of provider bulletins issued over reporting period (month and YTD).	N/A
	Webinars Conducted	Count of provider webinars conducted over reporting period (month and YTD); Narrative to report detail of events since previous bi-weekly (i.e. last two week)	N/A
	New Provider Orientations Conducted/Provider Visits	Count of provider orientation sessions and/or provider visits over reporting period (month and YTD); Narrative to report detail of events since previous bi-weekly (i.e. last two week)	N/A
Provider Network	New Providers contracts	Count of new provider contracts executed over reporting period (month and YTD).	N/A
	*Providers termed from network	Count of providers terminated from the network for any reason over the reporting period (month and YTD); Narrative to report if anomaly in the data is identified; Providers terminated for cause discussed at meeting	N/A
*Claims (Narrative to report if anomaly in the data is identified)	Number of claims received	Total count of claims received and accepted in the reporting period (month and YTD). This excludes claims adjusted and reprocessed by the MCO; additionally it does not include any claims received in prior months.	Monthly Claims Report; Total Claims (excluding dollars billed and includes pharmacy)

	Number of claims processed	Total count of clean claims for which an action has been taken on the claims (rejected, paid, denied, or pended if clean) over the reporting period (month and YTD); Includes Medical, Behavioral Health, and Pharmacy claims; Claims that have paid but include partial denials should be counted as paid.	N/A
	Claims Paid $ (Med / BH)	Total dollars paid of medical and behavioral health (excluding pharmacy) claims for which the final adjudication status has at least one paid line over the reporting period; paid claims with one or more denied claim lines, often referred to as "partially paid claims" will be considered paid claims for purposes of this report.	Monthly Claims Report; Total Claims Paid (excluding total count)
	Claims Paid $ (Rx)	Dollar amount of all claims that have been adjudicated as approved and were paid in the reporting month (and YTD).	Pharmacy Claims Report; Total Claims Approved and Paid (excluding total count)
	Percentage of claim rejects (Med / BH)	% of claims medical and behavioral health (excluding pharmacy) claims received over reporting period (month and YTD) rejected.	N/A
	*Percentage of claim denials (Med / BH)	% of claims medical and behavioral health (excluding pharmacy) claims in which the final adjudication status is denied and does not contain any paid claim lines over the reporting period (month).	N/A
	Turnaround time 10 day (Med/BH)	% of medical and behavioral health (excluding pharmacy) claims adjudicated within 10 days from the date the claim is received and accepted by the MCO to the date the claim is adjudicated over the reporting period (month and YTD).	N/A
	Turnaround time 60 day (Med/BH)	% of medical and behavioral health (excluding pharmacy) claims adjudicated within 10 days from the date the claim is received and accepted by the MCO to the date the claim is adjudicated over the reporting period (month).	N/A

Care Managemen t	Members in High Level Care Management	Count of members enrolled in high level/risk care management in the reporting period (month and YTD).	N/A
	Members in Medium Level Care Management	Count of members enrolled in medium level care management during the reporting period (month and YTD).	N/A
	Members in Low Level Care Management	Count of members enrolled in low/basic care management during the reporting period (month and YTD).	N/A
	Face to Face visits	Unduplicated count of in-person visits completed by care management staff (any member of the care management team) over the reporting period (month and YTD).	N/A
	% of Deliveries with "notice of pregnancy" rate	% of pregnancies that had a notice of pregnancy submitted by a provider out of all pregnancies in the reporting period (month and YTD).	N/A
	Care Management Meetings with Partners	Count of meetings care management staff conducted during the reporting period (month and YTD) with system partners including, but not limited to MLTC care management and/or quality meetings, other DHHS departments, other system partners, and community agencies. Excludes Director bi-weekly meetings and monthly operational meetings.	Event Submission Log
Pharmacy	Percentage of Generic Drugs dispensed	% of total pharmacy benefit drugs dispensed that were generic (not brand name) over the reporting period (month and YTD).	N/A
	PDL Compliance	PDL Compliance % over the reporting period (month)	PDL Compliance Report; PDL Compliance %
Quality	*New member Grievances received (Complaints)	Count of member complaints received in the reporting period (month and YTD). Narrative to report if anomaly in the data is identified.	
	% of Members Appeals Resolved within	% of member appeals resolved within 20 calendar days of being filed over the reporting period (month and YTD).	

	20 calendar days		
	Lead Screening in Children	Specifications per the QPP over the reporting period (quarterly and YTD).	
	Tdap Immunization rate for adolescents	Specifications per Governor's dashboard over the reporting period (quarterly and YTD).	
	Tdap Immunization rate for pregnant women	Specifications per the 2018 PIP over the reporting period (quarterly and YTD).	
	Well child visits within first 15 months	Specifications per Child Core Measure over the reporting period (quarterly and YTD).	
	Childhood Immunization-Combo 2	Specifications per CIS-HEDIS over the reporting period (quarterly and YTD).	
	Childhood Immunization-Combo 10	Specifications per CIS-HEDIS over the reporting period (quarterly and YTD).	
	17P-Compliance	Specifications per 2018 PIP over the reporting period (quarterly and YTD).	
Utilization Management (Med/BH)	Total authorization requests	Count of medical and behavioral (excluding pharmacy) prior authorization requests received during the reporting period (month and YTD).	
	*Authorization denial rate	% of authorizations denied out of the total authorization requests (above). Narrative to report if anomaly in the data is identified.	
	*ED Visits / 1000	Emergency Room department visits/1,000 based on paid claims for that month of date of service. Narrative to report if anomaly in the data is identified.	
	*IP Admissions / 1000	In-patient admissions/1,000 based on paid claims for that month of date of service. Narrative to report if anomaly in the data is identified.	
Finance	Revenue PMPM $	Revenue PMPM based on the MONTEL report.	
	Medical and Behavioral	Medical and Behavioral Health (excluding pharmacy) expenses over reporting period (month and YTD) incurred by date of service.	

	Health Expense PMPM $		
	Pharmacy Expense PMPM	Pharmacy expenses over reporting period (month and YTD) incurred by date of service.	

(shaded)	Topics be expanded upon in narrative
*	Provide Narrative if anomaly in data

Attachment 3: Provider Letter submitted to WellCare of Nebraska

It was a rough beginning. I started this position at Cirrus House last May with a growing stack of denials in my hands and a huge learning curve ahead.

No one here had any idea why the claims were being denied, not just for Wellcare, but for all of Medicaid. It was legitimate work that we were doing, so why weren't we being paid?

I picked up the pieces and ran with what I had. I ran straight into the same issues we had been having with all of the online claims.

After a few of these fruitless billing cycles I was given contact information for our Wellcare representatives. At first, that was Jessica Wykert, later we were put in touch with Michelle Hartman and Michelle Hand.

We started with phone calls and screen sharing, even getting a visit from Jessica and the local office's Lindsey Gonzales. Everyone there was very good about answering our questions and offering useful advice.

Most of the work on my end was learning exactly how claims needed corrected once they had been denied, and how to enter information on new claims to keep them from denying. This sounds easy enough, but it was months of trial and error that I'm referring to. By November, we were down to monthly follow up calls.

Keeping that line of communication open, be it e-mail or phone conversations, really made the whole process easier.

The start of 2018 saw only a few straggling claims that were still in need of attention. Michelle Hartman worked closely with me during this time to get those last issues cleaned up. By March, we were completely reconciled.

I'm happy to say that as of today we still are! All new claims go through smoothly thanks to the tools I was given by the wonderful representatives of Wellcare.

Thank you so much for your diligence! It had been a bumpy road getting to this point, but we truly appreciate all of your help.

Kalei Bechtold
Quality Improvement Coordinator
Cirrus House, Inc.

Attachment 4: Definitions of Compliance Domains and Levels of Compliance from IPRO's 2017 EQR

- Care Management—The evaluation of Care Management includes, but is not limited to, review of: policies and procedures for the MCO's care management program, health-risk assessment development and data collection, and file review of care management records.
- Provider Network—The evaluation of Provider Network includes, but is not limited to, review of: policies and procedures for confidentiality; direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity for primary care, specialists, hospital care and ancillary services; evidence of evaluation, analysis and follow-up related to program capacity monitoring; and enrollment and disenrollment and tracking of disenrollment data.
- Subcontracting—The evaluation of Subcontracting includes, but is not limited to, review of: policies and procedures for oversight of subcontractor performance, processes for identifying deficiencies and taking corrective action, and evidence of written contracts between the MCO and the subcontractor. Also reviewed are pre-delegation reports as well as reports that evidence ongoing monitoring and formal reviews of each subcontractor.
- Member Services and Education—The evaluation in this area includes, but is not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, Indian Health Protections, documentation of advance medical directives and medical record keeping standards. Also reviewed are informational materials, including the Member Handbook; processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis and follow-up regarding advance medical directives.
- Quality Management—The evaluation in this area includes, but is not limited to, review of: Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs); HEDIS® Final Audit Report (not applicable for this reporting year, as HEDIS data were not yet available); documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.
- Utilization Management—The evaluation in this area includes, but is not limited to, review of: policies and procedures for UM, UM Program Description, UM Program Evaluation, UM activities, and file review of denials.
- Grievances and Appeals—The evaluation of Grievances and Appeals includes, but is not limited to, a review of: policies and procedures for grievances and appeals, file review of member grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes and staff interviews.

Technical Methods of Data Collection

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCEs. For each set of standards reviewed, IPRO prepared standard-specific review tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- statement of federal regulation and related federal regulations;
- statement of state regulations;
- statement of state and MCO contract requirement(s);
- suggested evidence;
- reviewer determination;
- prior results (based on Readiness Review);
- descriptive reviewer findings and comments related to findings; and
- MCO response and action plan

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.

Reviewer findings on the tools formed the basis for assigning preliminary and final determinations. The standard determinations used are listed in the table below.

Standard Determinations	
Full Compliance	MCO has met or exceeded the standard
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action
Non-compliance	MCO has not met the standard

Attachment 5: Medical Acronym List

	MLTC Business Acronyms and Glossary of Terms
Terms	**Definitions**
[*the*] Act	Social Security Act
A&D or AD	Aged and Disabled (Medicaid Waiver)
AAA	Area Agency on Aging
AABD	Aid to the Aged, Blind and Disabled
AAAHC	Accreditation Association for Ambulatory Health Care
AAE	affirmative action employer
AAHAM	American Association of Healthcare Administrative Management
AAHP	American Association of Health Plans
AAMA	American Academy of Medical Administration
AAMC	Association of American Medical Colleges
AAPA	American Academy of Physician Assistants
AAPCC	adjusted average per capita cost
AARP	American Association of Retired Persons
ABA	American Bar Association; Applied Behavior Analysis
ABC	activity-based costing
ABM	activity-based management
ABN	advance beneficiary notice
ACA	Affordable Care Act
ACC	ambulatory care center
ACH	Automated Clearing House
ACHE	American College of Healthcare Executives
ACPE	American College of Physician Executives
ACPPD	average cost per patient day
ACR	adjusted community rate
ACS	ambulatory care services
ACT	Assertive Community Treatment
AD	admitting diagnosis
ADA	American Dietetic Association; American Dental Association
ADC	Aid to Dependent Children; average daily census
ADFS	alternative delivery and financing systems
ADHC	Adult Day Health Care
ADHS	Adult Day Health Services
ADL	Activities of Daily Living
ADP	automatic data processing
ADPL	average daily patient load
ADRC	Aging & Disabled Resource Center Grant

ADS	alternative delivery system
ADSC	average daily service charge
ADT	admission/discharge/transfer
AEP	appropriate evaluation protocol
AFDC	Aid to Families with Dependent Children
AFDS	alternative financing and delivery systems
AG	affiliated group; Attorney General
AHA	American Hospital Association
AHCA	American Health Care Association (long-term care)
AHIMA	American Health Information Management Association
AHIP	assisted health insurance plan
AICPA	American Institute of Certified Public Accountants
ALF	Assisted Living Facility
ALOS	average length of stay
ALW	Assisted Living Waiver
AMA	Against Medical Advice; American Medical Association
AMGA	American Medical Group Association
ANDI	Application & Document Imaging (Gold's Bldg)
ANSI	American National Standards Institute
AoA	Administration on Aging
AOCM	Administrative Outreach and Case Management
AOWN	Aging Office of Western Nebraska
A/P	accounts payable
APAAA	American Psychiatric Association; American Psychological Association
APAAA	Aging Partners Area Agency on Aging
APC	ambulatory payment classification
APD	Advance Planning Document
APG	ambulatory patient group
APHA	American Public Health Association
APHSA	American Public Human Services Association
API	Application Programming Interface
APPAM	Association for Public Policy Analysis and Management
APR	annual percentage rate
APS	Adult Protective Services
A/R	accounts receivable
ARRA	American Recovery and Reinvestment Act of 2009
AS	Department of Administrative Services
ASA	Adult Substance Abuse
ASC	ambulatory surgical/surgery center

ASC	X12 National Standard For Delivery and Maintenance of EDI Standards for the US
ASCII	American Standard Code for Information Interchange
ASO	Administrative Service Organization; administrative services only
ATO	Assistive Technology Only
ATP	Assistive Technology Partnership
AVG	ambulatory visit group
AVS	Asset Verification System
AWI	area wage index
AWP	average wholesale price
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act (1999)
BCD	binary code decimal
BEST	Benefit Eligibility Screening Tool
BH	Behavioral Health
BIP	Balancing Incentive Program
BLS	Bureau of Labor Statistics
BOL	bill of lading
BPM	Business Process Model
BQA	Bureau of Quality Assurance
BRAAA	Blue Rivers Area Agency on Aging
BRD	Business Requirements Document
BSDC	Beatrice State Developmental Center
BU	Business Unit
Budget Source	The department which will pay for a project. It is usually the Sponsor's department
CAA	Community Action Agencies
CAFR	Comprehensive Annual Financial Report
CAH	critical access hospital
CAP	Corrective Action Plan; Cost Allocation Plan
CAPTA	Child Abuse Prevention & Treatment Act
CARE	Comprehensive AIDS Resources Emergency (Act)
CASA	Community Aging Services Act
CBA	cost-benefit analysis
CBO	Congressional Budget Office
CBS	Claims Broker Services
CC	Child Care; complications and/or comorbidities
CCAA	Comprehensive Child and Adolescent Assessment
CCCD	Child Care for Children with Disabilities
CCH	Commerce Clearing House
CCI	correct coding initiative

CCMU	critical care medical unit
CCR	cost-to-charge ratio
CCRC	continuing care retirement community
CD	chemical dependency
CDC	Centers for Disease Control and Prevention
CE	continuing education
CEA	cost-effectiveness analysis
CEO	Chief Executive Officer
CER	capital expenditure review
CEU	continuing education unit
CF	Cystic Fibrosis
CFO	chief financial officer
CFR	Code of Federal Regulations
CFS	Children and Family Services
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Affairs
CHC	community health center
CHFP	Certified Healthcare Financial Professional
CHIP/SCHIP	comprehensive health insurance plan, Children's Health Insurance Program; Consumer Health Information Program
NECHIP	[NE] Comprehensive Health Insurance Pool
CHIPRA	CHIP Reauthorization Act [of 2009]
CHOICES	Choosing Home or In community Elder Services
CHP	comprehensive health planning
CILNE	Center for Independent Living of Central NE
CIO	chief information officer
CIS	computer information system
CM	Case Management; case mix
CME	continuing medical education
CMHC	community mental health center
CMI	case-mix index; chronic mental illness
CMN	certificate of medical necessity
CMP	competitive medical plan
CMS	Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration (HCFA)
CMS-64	Federal match claiming document
CMSCO	CMS Central Office
CMSRO	CMS Regional Office

CNA	Certified Nursing Assistant
CNH	community nursing home
CNHI	Committee for National Health Insurance
CNS	clinical nurse specialist
COA	Category of Aid
COB	coordination of benefits; close of business
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COLA	cost-of-living adjustment
CON	certificate of need
CONNECT	Coordinating Options in Nebraska's Network Through Effective Communications & Technology
COO	Concept of Operations (MITA); chief operating officer
CORF	comprehensive outpatient rehabilitation facility
CPA	certified public accountant
CP	Cerebral Palsy
CPE	Certified Public Expenditures
CPEHS	Consumer Protection and Environmental Health Service
CPEP	Carrier Performance Evaluation Program
CPI	Consumer Price Index
CPR	customary, prevailing, and reasonable
CPT	current procedural terminology (coding)
CPT-4	*Current Procedural Terminology,* Fourth Edition
CPU	central processing unit
CQI	continuous quality improvement
CSE	Child Support Enforcement
CSFP	Commodity Supplemental Food Program
CSHCN	Children with Special Health Care Needs
CSRA	Community Spouse Resource Allowance
CSW	Community Support Worker
CTA	Community Treatment Aid
CVH	Cardiovascular Health
CWF	common working file
CY	calendar year
D/A	date of admission
DBM	Dental Benefits Manager
DBMS	database management system
DC	diagnostic code
DCA	[DHHS] Division of Cost Allocation
DCP	Disabled Children's Program
DD	Developmental Disabilities

DDI	Design, Development, and Implementation
DDR	discharge during referral
DEFRA	Deficit Reduction Act
DHHS	Department of Health & Human Services
DI	disability insurance
DIB	disability insurance benefit
DISA	Data Interchange Standards Association
DJIA	Dow Jones Industrial Average
DMA	Data Management and Analytics
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DMS	see DBMS
DNI	Do Not Intubate Order
DNR	do not resuscitate
DOA	date of admission; dead on arrival
DOD	Department of Defense
DOE	Department of Energy; Department of Education
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DON	Director of Nursing
DOS	date of service
DOT	Department of Transportation
DP	data processing
DPFS	Disabled Persons and Family Support
DPH	Department of Public Health
DRA	Deficit Reduction Act
DRC	diagnosis-related category
DRG	diagnosis-elated group
DSH	disproportionate share hospital
DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition
DSO	debt service obligation
DUR	Drug Utilization Review (Board)
E&A	evaluate and advise
E&M	evaluation and management
EB	Enrollment Broker
EBCDIC	extended binary coded decimal information code
EBRI	Employee Benefit Research Institute
ECC	Enhanced Care Coordination
ECF	extended care facility

ECHO	electronic computing, health-oriented
ECI	employment cost index
EDI	electronic data interchange
EDIFACT	EDI for administration, commerce, and trade
EDN	Early Development Network
EDP	electronic data processing
EEO	equal employment opportunity
EEOC	Equal Employment Opportunity Commission
EES	Eligibility and Enrollment System
EFT	electronic funds transfer
EGHP	employer group health plan
EH	Eligible Hospital
EHIP	employee health insurance plan
EHR	Electronic Health Record
EI	Early Intervention
E-MAC	Enhanced Medical Assistance for Children
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Active Labor Act
ENOA	Eastern Nebraska Office on Aging
EO	executive order
EOB	explanation of benefits
EOC	episode of care
EOMB	explanation of medical benefits; Executive Office of Management and Budget; explanation of Medicare benefits
EOQ	economic order quantity
EP	Eligible Professional
EPA	Environmental Protection Agency
EPEA	expense per equivalent admission
EPFT	electronic payment funds transfer
EPO	exclusive provider organization
EPSDT	Early Periodic Screening Diagnosis and Treatment
ER	emergency room
ERISA	Employment Retirement Income Security Act
ERTA	Economic Recovery and Taxation Act
ES	emergency service
ESA	Employment Standards Administration
ESRD	end-stage renal disease
ESU	Educational Service Unit
ETGH	Enhanced Treatment Group Home
EVA	economic value added

F&A	fraud and abuse
FAC	freestanding ambulatory care
FAHS	Federation of American Health Systems
FAPA	Financial And Program Analysis
FAPE	Free Appropriate Public Education
FAQ	Frequently Asked Questions
FAS	Fetal Alcohol Syndrome
FASB	Financial Accounting Standards Board
FCBC	Fingerprint Based Criminal Background Check
FDA	Food and Drug Administration
FDO	formula-driven overpayment
FEC	freestanding emergency center
FERPA	Family Education Rights & Privacy Act
FFC	federal funding criteria
FFP	federal financial participation
FFS	fee for service
FFSS	fee-for-service system
FFY	federal fiscal year
FHA	Federal Housing Administration
FHFMA	Fellow of Healthcare Financial Management Association
FI	fiscal intermediary
FICA	Federal Insurance Contributions Act
FIFO	first in, first out
FIG	fiscal intermediary group
FIN	Federal Identification Number
FMAP	Federal Medical Assistance Percentages
FNS	Food and Nutrition Service
FOIA	Freedom of Information Act
FPR	Federal Procurement Regulations
FQHC	federally qualified health center
FR	*Federal Register*
FSI	Financial Strength Index
FTC	Federal Trade Commission
FTE	full-time equivalent
FWHF	Federation of World Health Foundations
FY	fiscal year
GAAP	generally accepted accounting principles
GAF	geographic adjustment factor
GAO	General Accounting Office
GDP	gross domestic product

GF	General Fund
GME	graduate medical education
GNP	gross national product
GPCI	geographic practice cost index
GPM	gross profit margin
GPO	Government Printing Office; group purchasing organization
H-B	Hill Burton Act
HA	Home Again
HAP	hospital accreditation program
HAR	hospital associated representatives
HAS	hospital administration services
HB	hospital based
HBO	hospital benefits organization
HBP	hospital-based physician
HC	health care; home care
HCBS	Home and Community Based Services
HCC	Health Care Consultancy; healthcare corporation
HCD	healthcare delivery
HCFA	Health Care Financing Administration, previous name for CMS. *See CMS*
HCFAR	Health Care Financing Administration ruling
HCPCS	Healthcare Common Procedure Coding System
HCRIS	Hospital Cost Reporting Information System
HCTA	healthcare trust account
HCUP	hospital cost and utilization project
HDM	Home Delivered Meals
HDS	health delivery system
HEAL	Health Education Assistance Loan
HEDIS	Health Plan Employer Data and Information Set
HEF	Health Education Foundation
HFMA	Healthcare Financial Management Association
HFPA	health facilities planning area
HFSG	healthcare financing study group
HH	Heritage Health; hold harmless
HHAG	Home Health Agency
HHO	home health organization
HHRG	home health resource groups
HHS	Health and Human Services (Department of)
HI	Hospital Insurance (refers to Medicare Part A)
HIAA	Health Insurance Association of America
HIBAC	Health Insurance Benefits Advisory Council

HIBCC	Health Insurance Business Communications Council
HIC	health information center; health insurance claim; health insurance company
HIE	Health Information Exchange
HINN	hospital-issued notice of noncoverage
HIP	health insurance plan
HIPAA	Health Insurance Portability & Accountability Act of 1996
HIPAA 5010	Latest Required HIPAA Electronic Version for X12 Transactions
HIPP	Health Insurance Premium Payment
HIS	hospital information system
HIT	Health Information Technology
HITECH	Health Information Technology for Economic & Clinical Health Act (part of Federal stimulus package)
HITF	health insurance trust fund
HMO	health maintenance organization
HMO/CMP	health maintenance organization/competitive medical plan
HMPSA	health manpower shortage area
HOPD	hospital outpatient department
HPAC	Health Policy Advisory Center
HPB	historic payment basis
HPC	Health Policy Council
HPMS	Health Plan Management System
HPR	hospital peer review
HR	House of Representatives; House Resolution
HRC	Hastings Regional Center;
HRET	Hospital Research and Education Trust
HRSA	Health Resources and Services Administration
HSA	Health Services Administration
HSQB	Health Standards and Quality Bureau
HSR	health services research
HSRC	Health Services Research Center
HUD	Housing and Urban Development (Department of)
HURA	Health Underserved Rural Area
HURT	hospital utilization review team
HV	hospital visit
I/O	input/output
IADL	Instrumental Activities of Daily Living
IAP	Innovation Accelerator Program
IAPD	Implementation Advance Planning Document

IBNR	incurred but not reported
ICD	*International Classification of Diseases*
ICD-9	*International Classification of Diseases, 9th revision*
ICD-9-CM	*International Classification of Diseases,* 9th revision, *Clinical Modification*
ICD-10	*International Classification of Diseases and Related Health Problems,* 10th revision
ICD-10-CM	*International Classification of Diseases and Related Health Problems,* 10th revision, *Clinical Modification*
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for Individuals with Mental Retardation
IDEA	Individuals with Disabilities Education [Improvement] Act
IDS	integrated delivery system
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IG	Inspector General
IGT	Intergovernmental Transfer
IHS	Indian Health Service
ILC	Independent Living Center
IMD	Institution for Mental Diseases
IME	indirect medical education
IMS	information management system
IO	investor owned
IOL	intraocular lens
IOV	initial office visit
IP	inpatient
IPA	individual practice association
IPF	Inpatient Psychiatric facilities
IPP	Individual Program Plan
IPS	interim payment system
IRF	Inpatient Rehabilitation Facilities
IRS	Internal Revenue Service
ISB	Independent Skills Building
ISS	Intermediate Specialized Services
IT	Information Technology
ITC	investment tax credit
IV&V	Independent Validation & Verification
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JCO	The Joint Commission

JIT	just in time
JUA	Joint Underwriting Association
KB	Katie Beckett
KC	Kids' Connection
KCRO	Kansas City Regional Office of CMS
KPI	Key Performance Indicator
LB	Legislative Bill
LBO	leveraged buyout
LCMS	Lancaster County Medical Society
LDAC	Licensed Drug & Alcohol Counselor
LDH	Licensed Dental Hygienist
LHD	League of Human Dignity
LHRC	Lasting Hope Recovery Center
LIFO	last in, first out
LIMHP	Licensed Independent Mental Health Practitioner
LMHP	Licensed Mental Health Practitioner
LMNT	Licensed Medical Nutrition Therapist
LOC	Level of Care
LOS	length of stay
LPN	licensed practical nurse
LRC	Lincoln Regional Center
LTC	long-term care
LTAC	Long Term Acute Care facility
LTCF	long-term care facility
LTCH	Long-Term Care Hospital
LTCOP	Long Term Care Ombudsman Program
LTCU	long-term care unit
LTD	long-term debt
LTSS	Long-Term Support and Services
LVN	licensed vocational nurse
M&A	merger and acquisition
M+C	Medicare+Choice
MAC	major ambulatory category; maximum allowable charge
MADC	mean average daily census
MADRS	Medicare Automated Data Retrieval System
MARS	Management and Administrative Reporting Subsystem
MB	market basket; Medicare Bureau
MLTC	Medicaid and Long-Term Care
MAAA	Midland Area Agency on Aging
MAAC	Medical Assistance Advisory Committee

MAC	Medical Assistance for Children
MACBIS	Medicaid and CHIP Business Information Solutions
MACPro	Medicaid and CHIP Program System
MAGI	Modified Adjusted Gross Income
MC	Managed Care
MCCA	Medicare Catastrophic Coverage Act [of 1988]
MCH	Maternal Child Health
MCO	managed care organization
MCP	Medical Claims Processing
MDC	major diagnostic category
MDS	minimum data set
MDT	Multidisciplinary [evaluation] Team
MEDISGRPS	Medical Illness Severity Grouping System
MEDLARS	Medical Literature Analysis and Retrieval System
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review file
MEI	Medicare economic index
MEP	Medicaid Eligibility Project
MER	Medicaid Eligibility Rate
MESC	Medicaid Enterprise Systems Conference
MET	multiple employer trust
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MFPAU	Medicaid Fraud and Patient Abuse Unit (see also MFCU)
MGC	Managed Care
MHCP	Medically Handicapped Children's Program
MHB	maximum hospital benefit
MHSA	Mental Health Substance Abuse
MIC	Medicaid Integrity Contractor
MIG	Medicaid Infrastructure Grant
MII	Medicaid Integrity Institute
MIP	Medicaid Incentive Payment
MIPS	Medicaid in Public Schools
MIS	management information system
MITA	Medicaid Information Technology Architecture
MIWD	Medicaid Insurance for Workers with Disabilities
MLP	mid-level practitioner
MLTC	Medicaid and Long-Term Care
MMI	Medical Management Institute; Munroe-Meyer Institute (NE Provider)

MMIS	Medicaid Management Information System
MMM	MITA Maturity Model
MN	Medically Needy
MNIL	Medically Needy Income Level
MNOPP	Medicaid Non Operations Project Portfolio
MOU	Memorandum Of Understanding
MOWAA	Meals on Wheels Association of America
MPFS	Medicare physician fee schedule
MPS	Medicare Savings Program
MR	management review
MRA	medical record administrator
MRD	medical record department
MRDF	machine-readable data file
MRI	magnetic resonance imaging; mortality risk index
MRO	Medicaid Rehab Option
MRP	maximum reimbursement point
MSA	metropolitan statistical area
MSIS	Medicaid Statistical Information System
MSO	medical service organization
MSP	Medicare secondary payer
MUA	medically underserved area
MVPS	Medicare volume performance standard
N4A	National Association of Area Agencies on Aging
NABHO	Nebraska Association of Behavioral Health Organizations
NAC	Nebraska Administrative Code
NACHA	National Automated Clearing House Association
NAHCHA	National Association for Home Care
NAHCHA	Nebraska Association of Home and Community Health Agencies
NAHSA	Nebraska Association of Homes and Services for the Aging
NAIC	National Association of Insurance Commissioners
NALA	Nebraska Assisted Living Association
NAMIS	Nebraska Aging Management Information System
NAMPI	National Association for Medicaid Program Integrity
NANASP	National Association of Nutrition and Aging Services Program
NAPH	National Association of Public Hospitals
NAR	net accounts receivable
NAS	Nebraska Advocacy Services; National Academy of Science

NASC	Nebraska Association of Senior Centers
NAMD	National Association of Medical Directors
NASUAD	National Association of States United for Aging and Disabilities
NBS	National Bureau of Standards
NCAHC	National Council on Alternative Health Care
NCCBH	National Council for Community Behavioral Healthcare
NCCI	National Correct Coding Initiative
NCHS	National Center for Health Services
NCI	National Cancer Institute
NCOA	National Council on Aging
NCQA	National Committee for Quality Assurance
NCS	Nebraska Casemix System
NDC	National Drug Code
NDE	Nebraska Department of Education
NEBMAC	Nebraska Education-Based Medicaid Administrative Claiming
NeHII	Nebraska Health Information Initiative
NENAAA	Northeast Nebraska Area Agency on Aging
NET	Non-Emergency Transportation
NF	nursing facility
NFA	net fixed assets
NFLOC	Nursing Facility Level of Care
NFMC	Nebraska Foundation for Medical Care
NFOCUS	Nebraska Family Online Client User System
NFP	not for profit
NH	nursing home
NHA	Nebraska Hospital Association
NHC	National Health Council
NHCA	Nebraska Health Care Association
NHCT	National Health Care Trust
NHF	National Health Federation
NHI	national health insurance
NHPCA	Nebraska Hospice and Palliative Care Association
NIH	National Institutes of Health
NIS	Nebraska Information System
NITC	Nebraska Information Technology Commission
NLR	National Level Repository
NMA	Nebraska Medical Association
NMAP	Nebraska Medical Assistance Program (Medicaid)
NMES	Nebraska Medicaid Eligibility Line
NMFP	Nebraska Money Follows the Person Project

NMHP	Nebraska Medical Home Pilot
NOA	notice of admission
NOI	net operating income
NOL	net operating loss
NonPAR	nonparticipating physician
NOR	nonoperating revenue
NP	nurse practitioner
NPI	national provider identifier
NPO	nonprofit organization
NPPES	National Plan and Provider Enumeration System
NPPR	notice of proposed rulemaking
NPR	notice of program reimbursement
NPRM	Notice of Proposed Rule Making
NPSR	net patient service revenue
NRHA	National Rural Health Association
NRRS	Nebraska Resource & Referral System
NS	Nutrition Services
NSF	not sufficient funds
NSIP	Nutrition Services Incentive Program
NSSRS	Nebraska Staff & Student Record System
NTAP	Nebraska Telephone Assistance Program
NTIS	National Technical Information Services
NTRAC	Nebraska Timely, Responsive, Accurate Customer Service
NUBC	National Uniform Billing Committee
OAA	Older Americans Act of 1965
OASDHI	Old Age Survivors, Disability, and Health Insurance Program
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OC	Organizational Change
OCIO	Office of the Chief Information Officer
OD	organizational development
ODR	Office of Direct Reimbursement
OHTA	Office of Health Technology Assessment
OIG	Office of Inspector General
OJT	on-the-job training
OMB	Office of Management and Budget
OOP	out of pocket
OP	outpatient
OPD	outpatient department
OPM	Office of Personnel Management

OR	operating room
OSG	Office of the Surgeon General
OSHA	Occupational Safety and Health Act; Occupational Safety and Health Administration
OT	Occupational Therapy
OTA	Office of Technology Assessment
OTC	over the counter
OWCP	Officer of Workers' Compensation Programs
P and T	Pharmacy and Therapeutics (Committee)
PA	public assistance; physician assistant
PAC	preadmission certification
PACE	Program of All-Inclusive Care for the Elderly
PAM	patient accounts manager
PAO	Personal Assistance Organization
PAPD	Planning Advance Planning Document
PAR	participating (provider or supplier)
PAS	Personal Assistance Services
PASRR	Pre-Admission Screening and Resident Review
PASRRP	Pre-Admission Screening and Resident Review Process
PASS	Personal Assistance Services (4 letters needed for NFOCUS entries)
PBM	Pharmacy Benefits Manager
PCA	Personal Care Association
PCCM	Primary Care Case Management
PCG	Public Consulting Group
PCMH	Patient-Centered Medical Home
PCP	primary care physician
PCS	Personal Care Services
PDAC	Professionally Licensed Drug & Alcohol Counselor
PDL	Preferred Drug List
PDN	Private Duty Nursing
PE	physician extender
PERM	Payment Error Rate Measurement
PERS	Personal Emergency Response System
PHCY	Pharmacy
PHI	Personal Health Information
PHN	Public Health Nurse
PHO	physician hospital organization
PI	Program Integrity
PL	Public Law
PM	Project Manager; program memorandum

PMO	Project Management Office
PMPM	per member per month
PNA	Personal Needs Allowance
PO	Purchase Order; physician organization
POA	Power of Attorney; Present on Admission
POAM	Plan of Action and Milestones (MITA)
POS	point of service; point of sale; place of service; Paid by Other Sources
POSS	Plan of Services and Supports
PPA	preferred provider arrangement
PPACA	Patient Protection and Affordable Care Act
PPD	per patient day; prepaid
PPM	physician practice management
PPO	preferred provider organization
PPS	prospective payment system
PQA	Pharmacy Quality Alliance
PR	peer review
PRO	peer review organization
ProPAC	Prospective Payment Assessment Commission
PRP	prospective reimbursement plan
PRRB	Provider Reimbursement Review Board
PRTF	Psychiatric Residential Treatment Facilities
PSE	Provider Screening and Enrollment
PSO	provider-sponsored organization
PT	Physical Therapy
QA	quality assurance
QAM	quality assurance monitor/monitoring
QAP	quality assurance program
QAS	quality assurance standards
QA/RM	quality assurance/risk management
QA/UR	quality assurance/utilization review
QI	Qualified Individuals
QLI	Quality Living Inc. (Provider)
QM	quality management
QMB	Qualified Medicare Beneficiary
R&D	research and development
RA	Remittance Advice
RAC	Recovery Audit Contractor
RAD	Rapid Application Development
RBRVS	resource-based relative value scale
RCC	ratio of cost to charges

RD	Resource Development; Resource Developer
RDR	Revised Draft Regulations
REC	Regional Extension Center
REIT	real estate investment trust
RFI	request for information
RFP	request for proposal
RFQ	request for quotation
RHA	regional health administrator
RHC	rural health clinic
RHP	regional health planning
RIF	reduction in force
RM	risk management
RMIS	risk management information systems
RMS	Random Moment Study
RN	Registered Nurse
ROE	return on equity
ROI	return on investment
RPCH	rural primary care hospital
RRC	rural referral center
RRS	Reissue Revised Statute(s)
RSA	Resident Service Agreement
RTC	Residential Treatment Center
RTU	relative time unit
RUG	Resident Utilization Group; resource utilization group
RUP	Rational Unified Process
RVS	relative value scale/schedule/study
RVU	relative value unit
S&P	Standard and Poor's
SAM	School Age Medical
SAT	Student Assistance Team
SB	Senate Bill (National)
SBU	strategic business unit
SC	Senior Center
SC	Services Coordinator
SCH	sole community hospital
SCNAAA	South Central Nebraska Area Agency on Aging
SCO	Senior Care Options
SCP	sole community provider
SCR	System Change Request
SD	standard deviation
SDLC	System Development Life Cycle

SDP	State Disability Program
SE	standard error
SEC	Securities and Exchange Commission
SE-MAC	Special Enhanced Medical Assistance for Children
SENHIE	Southeast Nebraska Health Insurance Exchange 12.SFTP-Secure File Transfer Protocol
SFMNP	State Farmers Market Nutrition Program
SFY	State Fiscal Year
SG	Surgeon General
SGF	State General Fund
SGO	Surgeon General's Office
SGR	sustainable growth rate
SHA	state health agency
SHC	state health commissioner
SHIIP	Senior Health Insurance Information Program
SHIP	State Health Insurance Program
SHO	State Health Official
SI	severity index
SLA	Service Level Agreement
SLIMB	Special Low Income Medicare Beneficiary
SLP	Speech-Language Pathology
SLR	State Level Repository
SMD	State Medicaid Directors
SME	Subject Matter Expert
SMHP	State Medicaid Health Information Technology Plan
SMHP	State Medicaid Health Insurance Technology Program
SMI	Supplementary Medical Insurance (refers to Medicare Part B)
SMM	State Medicaid Manual
SMP	State Medicaid Plan
SMP	Nebraska Senior Medicare Patrol
SNAP	Supplemental Nutrition Assistance Program
SNF	skilled nursing facility
SNP	Special Needs Plan
SOA	Service Oriented Architecture
SOB	statement of benefits
SOC	Share of Cost; standard of care
SOI	severity of illness
SOP	standard operating procedures
SOTA	State Operations and Technical Assistance (CMS)
SP	standard of performance

SPA	State Plan Amendment; state planning agency
SPB	State Purchasing Bureau
SPCM	Specialized Primary Care Management
SPMP	Skilled Professional Medical Personnel
SPR	State Program Reports
SR	Senate Resolution
SRT	State Review Team
SSA	Social Security Administration
SSAD	Social Services Block Grant for Aged and Disabled (N-Focus program name)
SSBG	Social Services Block Grant
SSCF	Social Services Block Grant for Children and their Families (N-Focus program name)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSOP	Second Surgical Opinion Program
ST	Speech Therapy
STD	Sexually Transmitted Diseases; short-term disability
SUA	Nebraska State Unit on Aging
SUBC	State Uniform Billing Committee
SURS	Surveillance and Utilization Review System
T&E	travel and expense; trial and error
TAAC	Technology Assessment Advisory Council
TAG	Technical Advisory Group (CMS)
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TDA	tax-deferred annuity
TEC	Technical Extension Center
TEFRA	Tax Equity and Fiscal Responsibility Act
TEP	Temporary Educational Permit
TFC	Treatment Foster Care
TGH	Treatment Group Home
ThGH	Therapeutic Group Home
TIPS	Tracking Infant Progress Statewide
Title II	Title II of the Social Security Act-Federal Old-Age, Survivors, and Disability Insurance Benefits
Title XIX	Title XIX of the Social Security Act – Medicaid
Title XX	Title XX of the Social Security Act-Social Services Block Grant
Title XXI	Title XXI of the Social Security Act – State Children's Health Insurance Program

TMA	Transitional Medical Assistance; third-party administrator
TPL	Third Party Liability
TPR	Third Party Resources
TQM	total quality management
TR	turnover rate
TSA	tax-sheltered annuity
UAT	User Acceptance Testing
UB	uniform billing
UB-92	Uniform Billing-Form 92
UBI	unrelated business income
UCAS	Uniform Cost Accounting Standards
UCR	usual, customary, and reasonable
UHCIA	Uniform Health Care Information Act
UHDDS	Uniform Hospital Discharge Data Set
UI	User Interface
UM	utilization management
UNMC	University of Nebraska Medical Center
UPC	Uniform Product Code
UR	utilization review
USC	United States Code
USDA	U.S. Department of Agriculture
USDT	U.S. Department of Transportation
USFMG	U.S. foreign medical graduate
USFMSS	U.S. foreign medical school student
USMG	U.S. medical graduate
USPCC	U.S. per capita cost
USPHS	U.S. Public Health Service
USSG	U.S. Surgeon General
VA	Veterans Administration; Veterans' Affairs
VAH	Veterans' Affairs Hospital
VNA	Visiting Nurse Association
VR	Vocational Rehabilitation
WC	Workers' Compensation
WCNAAA	West Central Nebraska Area Agency on Aging
WD	Working Disabled
WHF-USA	World Health Foundation, United States of America
WHO	World Health Organization
WIC	Women, Infants and Children
WIN	Work Incentives Network
XR	x-ray

YTD	year-to-date
ZBB	zero-base budgeting
ZPG	zero population growth