State of Nebraska
Department of Health and Human Services
Division of Medicaid and Long-Term Care

Annual External Quality Review Technical Report
Managed Care of North America (MCNA) Dental

Measurement Years 2017–2018
April 2019

IPRO
Better healthcare, realized.

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Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 established that state agencies contracting with the following Managed Care Entities (MCEs), provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCE: Medicaid Managed Care Organizations (MCOs), Prepaid Ambulatory Health Plans (PAHPs), Prepaid Inpatient Health Plans (PIHPs), and Primary Care Case Management (PCCM). Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCEs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCE. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS). Quality, as it pertains to an EQR, is defined in 42 CFR 438.320 as "The degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional, evidence-based knowledge."

These same federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality, timeliness, and access to health care services that MCEs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCEs regarding health care quality, timeliness, and access, as well as make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCEs.

To meet these federal requirements, the Nebraska Department of Health and Human Services (NE DHHS) has contracted with Island Peer Review Organization (IPRO), an external quality review organization, to conduct the annual EQR of Managed Care of North America (MCNA) Dental, referred to in this report as MCNA.

Scope of EQR Activities Conducted

This EQR technical report focuses on the two federally mandated EQR activities that were conducted (note the third federally mandated EQR activity, performance measure validation, is not applicable for the measurement period reflected within this report). As set forth in 42 CFR 438.358, the two activities that were conducted were:

Compliance Review – This review determines MCE compliance with its contract and with state and federal regulations in accordance with the requirements of 42 CFR 438 Subpart E.

Validation of Performance Improvement Projects (PIPs) – Three PIPs were reviewed to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

CMS defines *validation* in the Final Rule in 42 CFR 438.320 as "The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of the EQR activities performed by IPRO are detailed in the **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** section of this report.

Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding MNCA's strengths and IPRO's recommendations with respect to quality, timeliness and access. For the remaining EQR activities conducted by IPRO in 2018, specific findings, strengths and recommendations are described in detail in **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** in this report.

Quality

The quality domain encompasses PIP activities and findings from six (6) of the seven (7) compliance domains: Member Services, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management.

PIPs

In calendar year (CY) 2018, MCNA proposed a PIP to increase the percentage of members receiving annual dental visits. The PIP employs the modified HEDIS Annual Dental Visit (ADV) measure, stratified into three age groups: 2–20 years, 1–20 years, and 21+ years. The baseline period for the PIP was 1/1/18–12/31/18. Analysis of MCNA's baseline data showed the ADV rate for ages 2–20 was 68.2%, the rate for ages 1–20 was 64.9%, and the rate for ages 21+ was 42.6%. The final goal for ages 2–20, 1–20, and 21+ were 69.7%, 67.9%, and 44.1%, respectively.

MCNA is also conducting a PIP to address members receiving preventive dental care at least twice per year. The PIP employs two (2) performance indicators: percentage of members who received at least one (1) preventive dental service during the measurement year (two age strata: 1–20 years and 21+ years), and percentage of members who received at least two (2) preventive dental services 6 months apart during the measurement year (age strata: 1–20 years and 21+ years). The baseline period for the PIP was 1/1/18–12/31/18. The baseline rates for the percentage of members who received at least one (1) preventive dental service for the members aged 1–20 and 21+ were 54.6% and 21.0%, respectively. MCNA aims to increase this rate to 58.6% for the 1–20 years age group and to 23.0% for the 21+ age group. The baseline rates for the percentage of members who received at least two (2) preventive dental services for members aged 1–20 and 21+ were 27.1% and 8.4%, respectively. MCNA aims to increase this rate to 30.1% for the 1–20 years age group and to 10.4% for the 21+ age group.

Analysis of performance indicator data will be available in the reporting year (RY) 2020 annual technical report.

Compliance Review

MCNA received a "full compliance" designation for Subcontracting, Quality Management, and Provider Services, and a "substantial compliance" designation for Grievances and Appeals, Utilization Management, and Member Services and Education. MCNA received a "minimal compliance" designation for one element under Member Services and Education:

- Of the 38 standards/substandards reviewed for Grievances and Appeals, 34 standards/substandards were fully compliant and four (4) were substantially compliant. Three substantially compliant standards/substandards were related to quality. The following details findings from the review of the substantially compliant standards:
  - Ensure that there is only one level of appeal for members. This requirement is not explicitly stated within the dental benefits program manager (DBPM)'s policies and procedures.
  - Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. This requirement was partially addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2; however, there is an opportunity to make this policy more transparent.
  - The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution. This language was not clear in member letters.

- Of the 51 standards/substandards reviewed for Member Services and Education, 47 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. The following details findings from the review of these substantially and minimally compliant standards:
  Substantially Compliant Standards
  - The extent to which, and how, after-hours and emergency coverage are provided, including that, when necessary, members should refer to their Heritage Health member information for emergencies relating to the member's physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM. There is only reference made to Heritage Health in the context of prescription coverage.
  - The member handbook should contain information about member co-payments; however, there is no language pertaining to co-payments.

- The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). The DBPM's website provided neither an accessibility feature for members with visual impairments nor the capability for bi-directional communications.

Minimally Compliant Standard

- Any additional information that is available upon request, including but not limited to: a. structure and operation of the DBPM, b. the DBPM dentist incentive plan (42 CFR 438.6), c. DBPM service utilization policies, d. how to report alleged marketing violations to Medicaid and Long-Term Care (MLTC), and e. reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state. This requirement is addressed on page 34 of the member handbook for sub-element d only.

- Of the 48 standards/substandards reviewed for Utilization Management, 45 standards/substandards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. The following details findings from the review of the substantially compliant standard for the domain of quality:
  - As part of the DBPM appeal procedures, the DBPM must include an informal reconsideration process that allows the member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. None (0) of the 10 files reviewed included information about informal reconsideration in the notice of action letter.

In the domain of quality, IPRO recommends that MCNA:

- Incorporate language pertaining to only one level of member appeal into MCNA's policies and procedures and in their member handbook and provider manual.
- Add language in Policy 13.100 Grievances and Appeals Department Overview to reflect contractual requirement IV.H.1.b.3, that the individual addressing the member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: the denial of service is based on lack of medical necessity; because of the member's medical condition, the grievance requires expedited resolution; or the grievance or appeal involves clinical issues.
- Add language to the member handbook that the member should contact their Heritage Health Plan for information regarding emergencies relating to the member's physical and behavioral services in addition to the pharmaceutical services, as those benefits are not reimbursed by the DBPM.
- Add language to the member handbook pertaining to co-payments.
- Add an easily accessible feature to MCNA's website to accommodate the visually impaired who have difficulty reading. It is also recommended that a bi-directional communication capability be considered for members to obtain real-time answers to questions.
- Add additional information to the member handbook to ensure members are aware that they can request information related to the structure/operation of the DBPM, the dentist incentive plan, service utilization policies, and reports of transactions between the DBPM and parties of interest.

Timeliness

The timeliness domain includes findings from two (2) of the seven (7) compliance domains: Utilization Management, and Grievances and Appeals.

Compliance Review

- Of the 38 standards/substandards reviewed for Grievances and Appeals, 34 standards/substandards were fully compliant and four (4) were substantially compliant. One substantially compliant standard/substandard was related to timeliness. The following details findings from the review of the substantially compliant standard:
  - The DBPM must acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.

- Of the 48 standards/substandards reviewed for Utilization Management, 45 standards/substandards were fully compliant, two (2) were substantially compliant, and one (1) was not applicable. The following details findings from the review of the substantially compliant standard for the domain of timeliness:
    - The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than 14 calendar days following receipt of the request for service unless an extension is requested. In no instance must any determination of standard service authorization be made later than 25 calendar days from receipt of the request.

In the domain of timeliness, IPRO recommends that MCNA:

- Remove the language related to a state fair hearing from the grievance acknowledgement letter, since state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).
- Clarify the language in the acknowledgement letter as to how state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).
- Develop a policy that clearly states that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard versus extended).
- Include information about informal reconsideration in the notice of action to the member.

Access

The access domain includes findings from one (1) of the seven (7) compliance domains: Provider Network.

Compliance Review

MCNA received a "full compliance" designation for Provider Network.

There are no recommendations in the domain of access at this time.

Background

Nebraska Medicaid Managed Care Program: Heritage Health

The State of Nebraska's Medicaid Program is administered through the Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care. The Medicaid program provides health care coverage for approximately 230,000 individuals.

Managed care was developed to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health care services in a cost effective manner. This program has steadily evolved since 1995, from an initial program that provided physical health benefits in three counties, to the current one that provides a full-risk, capitated Medicaid managed care (MMC) program for physical health (PH), behavioral health (BH), and pharmacy services statewide.

The Nebraska MMC Program, formerly referred to as the Nebraska Health Connection (NHC), was implemented in July 1995 with two separate 1915(b) waivers: one for PH and one for mental health and substance use disorders (SUDs), with full-risk BH managed care effective September 2013. In October 2015, following a request for proposal (RFP) for their new integrated MMC Program, referred to as Heritage Health, NE DHHS contracted with three MCOs to each provide physical health care, behavioral health care, and pharmacy services for their Medicaid and Children's Health Insurance Program (CHIP) enrollees beginning January 1, 2017. Notable changes associated with the implementation of this program include the integration of physical and behavioral health care through three MCO contracts for all 93 counties in the state of Nebraska (see **Table 1**); inclusion of pharmacy services in the core benefit package and the MCO capitation rate; inclusion of the aged, blind, and disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services; and the expansion of enrollment broker services to complete the process of member enrollment. Further, NE DHHS contracted with one dental benefits program manager, MCNA, which started operations in October 2017, across all 93 counties.

Table 1: Nebraska MCEs and Counties

MCEs	Counties
• Nebraska Total Care • UnitedHealthcare Community Plan of Nebraska • WellCare of Nebraska • Managed Care of North America (MCNA) Dental	Adams, Antelope, Arthur, Banner, Blaine, Body, Boone, Box Butte, Brown, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Sarpy, Saunders, Seward, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler, and York

MCE: managed care entity.

MCNA is contracted by DHHS to provide services as a DBPM to Medicaid recipients residing in the counties noted above. For the month of December 2018, MCNA's membership totaled 240,677.

Medicaid populations who are mandated to participate in the Nebraska MMC Program include:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups;
2. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability;
3. Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population;
4. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, CHIP;

5. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement;
6. Medicaid beneficiaries who participate in a HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the state's 1915(c) waiver of the Social Security Act;
7. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters);
8. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined; and
9. Members eligible during a period of presumptive eligibility.

DHHS currently contracts with vendors to perform the following services for Heritage Health:
1. Physical health managed care services,
2. Behavioral health managed care services,
3. Enrollment broker services,
4. External quality review services,
5. Actuarial services, and
6. Pharmacy benefit management services.

The MMC Program offers clients expanded choices, increased access to primary care, greater coordination and continuity of care, cost-effective quality health services, and better health outcomes through effective care management.

Nebraska Quality Goals and Objectives

NE DHHS developed the MMC Program to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost-effective to the state. The objectives of the program continue to be improved access to quality care and services, improved client satisfaction, reduction of racial and ethnic health disparities, cost reduction, and the reduction/prevention of inappropriate/unnecessary utilization.

As BH services are added to the physical health delivery system under Heritage Health, goals for all members include decreased reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment.

NE DHHS also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes:
- Improve health outcomes;
- Enhance integration of services and quality of care;
- Place emphasis on person-centered care, including enhanced preventive and care management services (focusing on the early identification of members who require active care management);
- Reduce rate of costly and avoidable care;
- Improve financially sustainable system;
- Increase evidence-based treatment;
- Increase outcome-driven community-based programming and support;
- Increase coordination among service providers;
- Promote a recovery-oriented system of care; and
- Expand access to high-quality services (including hospitals, physicians, specialists, pharmacies, mental health and SUD services, federally qualified and rural health centers, and allied health providers) to meet the needs of NE's diverse clients.

The state supplies MCEs with race, ethnicity, and primary language information about Medicaid enrollees that has been collected during intake and eligibility procedures. The state expects the MCE to use the information to promote delivery of services in a culturally competent manner and to reduce racial and ethnic health disparities for enrollees.

The state has had success with prenatal incentive and emergency room divergence programs. Building on these successes, and successful performance improvement projects (PIPs) carried out by MCEs, the state hopes to continue improving clinical and nonclinical care aspects with proactive and effective programming.

External Quality Review Activities

Over the course of 2018, IPRO conducted a compliance monitoring site visit and validation of PIPs for MCNA. Each activity was conducted in accordance with CMS protocols for determining compliance with Medicaid Managed Care regulations. Details of how these activities were conducted are described in **Appendices A and B** and address:

- Objectives for conducting the activity,
- Technical methods of data collection,
- Descriptions of data obtained, and
- Data aggregation and analysis.

Conclusions drawn from the data and recommendations related to access, timeliness and quality are presented in the **Executive Summary** section of this report.

Corporate Profile

MCNA is a DBPM operated by Managed Care of North America Insurance Company. MCNA offers coverage in all 93 counties. See **Table 2** for a summary profile.

Table 2: Managed Care of North America Dental Corporate Profile

Field	Details
Type of organization	PAHP
Product line(s)	Medicaid
Total Medicaid enrollment (as of 12/2018)	240,677
URAC (expiration date 12/1/2020)	Fully accredited

PAHP: prepaid ambulatory health plan; URAC: Utilization Review Accreditation Committee.

Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access

Introduction

This section of the report addresses the findings from the assessment of MCNA's strengths and areas for improvement related to quality, timeliness and access. The findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Accreditation, and Validation of Performance Improvement Projects).

Compliance Monitoring

This subpart of the report presents the results of the review by IPRO of MCNA's compliance with regulatory standards and contract requirements for September 1, 2017–March 31, 2018. The review is based on information derived from IPRO's conduct of the annual regulatory compliance review, which took place in May 2018. IPRO's assessment methodology is consistent with the protocols established by CMS and is described in detail in **Appendix A**.

A summary of the results is provided below in **Table 3**. For each compliance domain, a description is provided including: content reviewed, overall compliance designation, current year findings and recommendations (measurement period 9/1/17–3/31/2018), and MCNA's response and action plan. IPRO will assess the effectiveness of MCNA's actions during the next annual compliance review.

Table 3: Summary of Compliance Review Findings

Compliance Domain	Compliance 2018 (Measurement Period 9/1/17–3/31/18)										
	n=	F		S		M		NC		N/A	
Provider Network	42	42	100%	0	0%	0	0%	0	0%	0	0%
Provider Services	3	3	100%	0	0%	0	0%	0	0%	0	0%
Subcontracting	4	4	100%	0	0%	0	0%	0	0%	0	0%
Member Services and Education	51	47	92%	3	6%	1	2%	0	0%	0	0%
Quality Management	28	20	71%	0	0%	0	0%	0	0%	8	29%
Utilization Management	48	45	94%	2	4%	0	0%	0	0%	1	2%
Grievances and Appeals	38	34	89%	4	11%	0	0%	0	0%	0	0%

F: full compliance (green shading); S: substantial compliance (blue shading); M: minimal compliance (yellow shading); NC: non-compliant (pink shading); N/A: not applicable (gray shading).

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.

A total of 42 standards/substandards were reviewed; all were fully compliant.

Provider Services

The evaluation of provider services includes, but is not limited to, review of: policies and procedures for provider complaint system, and processes implemented in response to tracking/trending of provider complaints. Also reviewed are provider complaint files.

A total of three (3) standards/substandards were reviewed; all were fully compliant.

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.

A total of four (4) standards/substandards were reviewed; all were fully compliant.

Member Services and Education

The evaluation of member services and education 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.

A total of 51 standards/substandards were reviewed; 47 were fully compliant, three (3) were substantially compliant, and one (1) was minimally compliant. Member services and education substantially compliant standards/substandards are presented in **Table 4**. Member services and education minimally compliant standards/substandards are presented in **Table 5.**

Table 4: Member Services and Education – Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
19. The extent to which, and how, after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c). b. That prior authorization is not required for emergency services. c. The process and procedures for obtaining emergency services, including use of the 911 telephone system. d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care. e. That, when necessary, members should refer to their Heritage Health member information for emergencies relating to the member's physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM.	Requirements a–d are addressed on page 19 of the member handbook. Requirement e is not fully addressed; there is only reference made to Heritage Health in the context of prescription coverage. **Recommendation:** The member handbook should contain language that the member should contact their Heritage Health Plan for information regarding emergencies relating to the member's physical and behavioral services in addition to the pharmaceutical services, as those benefits are not reimbursed by the DBPM.	Content was added on page 21 of the member handbook.
23. Information about member co-payments.	This requirement is partially addressed on page 10 of the member handbook, wherein reference is made to services that are not covered, as well as how members under age 21 do not have to	There are no co-payments. This language can be found on page 11 of the member handbook.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	pay for medically necessary dental services. The handbook further specifies that dental coverage is limited to $750 per fiscal year for individuals aged 21 years and older. **Recommendation:** Language pertaining to co-payments should be added in the member handbook.	
Member website: The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). The DBPM website must include general and up-to-date information about the Nebraska Medicaid program and the DBPM. The DBPM must remain compliant with applicable privacy and security requirements (including, but not limited to, HIPAA) when providing member eligibility or member identification information on its website. The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the act sets for people with visual impairments and disabilities that make usability a concern. The DBPM website must follow all written marketing guidelines included in Section IV G - Member Services and Education. Use of proprietary items that would require use of a specific browser or other interface is not allowed.	All the requirements are addressed in the website development and maintenance policy. The DBPM's website is accessible from a mobile device. The privacy policies are all visible and accessible at the bottom of the home page, as well as the TTY (hearing-impaired) number. The DBPM has a mobile application named MyMCNA for both Android and Apple device users that can be downloaded for free for all members. In addition, the DBPM has utilized social media such as Facebook, Twitter, and YouTube as another means of communication and to provide updates, information, and education to members in both their pediatric and adult populations. The DBPM's website did not provide an accessibility feature for members with visual impairments, nor the capability for bi-directional communications. The DBPM has discussed that most of their members call the office if they have questions. Some members also email MCNA. If the email is submitted during off-hours, the DBPM will respond the next business day. **Recommendation:** An easily accessible feature should be added to MCNA's website to accommodate the visually impaired who are not able or have difficulty reading regular print (an onsite demonstration showed how the member can enlarge font by pressing "control" and "+" at the same time on their keypads; however, there is an opportunity to provide this instruction on the website, in the event members are not well-versed in how to manipulate font size digitally). It is also	N/A (no response received).

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	recommended that a bi-directional communication capability be considered for members to obtain real-time answers to questions.	

MCNA: Managed Care of North America; CFR: code of federal regulations; DBPM: dental benefits program manager; HIPAA: Health Insurance Portability and Accountability Act; TTY: text telephone; MCNA: Managed Care of North America; N/A: not applicable.

Table 5: Member Services and Education – Minimally Compliant Standards/Substandards

Minimally Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
29. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the DBPM. b. The DBPM dentist incentive plan (42 CFR 438.6). c. The DBPM service utilization policies. d. How to report alleged marketing violations to MLTC. e. Reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state.	This requirement is addressed on page 34 of the member handbook for sub-element d only. **Recommendation:** All the sub-elements of this requirement should be included in the member handbook to ensure members are aware that they can request information related to the structure/operation of the DBPM, the dentist incentive plan, service utilization policies, and reports of transactions between the DBPM and parties of interest.	The language was added to the member handbook on page 36.

MCNA: Managed Care of North America; DBPM: dental benefits program manager; CFR: code of federal regulations; MLTC: Medicaid and Long-Term Care.

Quality Management

The evaluation of quality management 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; PIPs; documentation related to performance measure calculation, reporting, and follow-up; and evidence of internal assessment of accuracy and completeness of encounter data.

A total of 28 standards/substandards were reviewed; 20 were fully compliant and eight (8) were deemed not applicable.

Utilization Management

The evaluation of utilization management includes, but is not limited to, review of: policies and procedures for Utilization Management (UM), UM Program Description, UM Program Evaluation, UM activities, and file review of denials.

A total of 48 standards/substandards were reviewed; 45 were fully compliant, two (2) were substantially compliant, and one (1) was deemed not applicable. Utilization management substantially compliant standards/substandards are presented in **Table 6**.

Table 6: Utilization Management– Substantially Compliant Standards/Substandards

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
Timing of Service Authorization Decisions Standard Service Authorization: 1. The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. 2. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the DBPM justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request. If the DBPM extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The DBPM must issue and carry out its determination as expeditiously as the member's health condition requires, but no later than the date the extension expires.	This requirement is addressed in the service authorizations including retrospective reviews policy on page 3 and in the UM program description on pages 12 and 19. Although the service authorization including retrospective reviews policy clearly outlines the fourteen (14)-calendar-day requirement for standard service authorization and the additional fourteen (14) calendar days for the extension, neither this policy nor any other policy submitted by the plan indicated that the maximum cap for a service authorization to reach a determination is twenty-five (25) calendar days. Ten (10) of 10 UM denial files were reviewed and all were standard service authorizations. Of these, all 10 met the requirement of determination within fourteen (14) calendar days. Nine (9) out of 10 files were given a determination within two (2) business days, which shows that the plan exceeded the requirement of 80% of standard service authorizations getting a determination within two (2) days. **Recommendation:** The policy should clearly state that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard versus extended). File review evidences that the DBPM is indeed meeting this requirement; however, policies must also include this requirement.	The recommended update was completed after the onsite comments were received from the EQRO. The policy was updated and approved by the UM Committee and QIC.
Informal Reconsideration: 1. As part of the DBPM appeal procedures, the DBPM must include an informal reconsideration process that allows the member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.	This requirement is addressed in the member handbook on page 30, the provider manual on page 59, and in the informal reconsideration process policy. Ten (10) of 10 files were reviewed and none (0) had an informal reconsideration; therefore, this	Informational denial information will be added to the letter and submitted to MLTC for approval.

Substantially Compliant Standards/Substandards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
2. In a case involving an initial determination, the DBPM must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination. 3. The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical peer designated by the dental director if the dentist who made the adverse determination cannot be available within one (1) business day. The informal reconsideration will in no way extend the 30-day required timeframe for a notice of appeal resolution.	requirement was not applicable for the files reviewed. However, since informal reconsideration is a potential immediate next step after an adverse determination, the notice of action letters should include information about informal reconsideration. None (0) of the 10 files reviewed included information about informal reconsideration in the notice of action letter. **Recommendation:** The notice of action to the member and the provider should include information about informal reconsideration.	

MCNA: Managed Care of North America; DBPM: dental benefits program manager; MLTC: Medicaid and Long-Term Care; UM: utilization management; EQRO: external quality review organization; QIC: Quality Improvement Committee.

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.

A total of 38 standards/substandards were reviewed; 34 standards/substandards were fully compliant and four (4) were substantially compliant. Grievances and appeals substantially compliant standards/substandards are presented in **Table 7**.

Table 7: Utilization Management – Substantially Compliant Standards/Substandards

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	This requirement is addressed in MCNA's formal grievance procedure policy, and Policy 13.200 Member Appeals. Four (4) grievance files were available for review during the measurement period. Ten (10) appeal files were reviewed. All files contained evidence of this requirement.	The recommended update to remove the state fair hearing language from the grievance acknowledgement letter has been completed.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	It was suggested onsite that the DBPM include the nature of the grievance in the acknowledgement letter, in the event the member has multiple grievances, for instance. Further, the language related to a state fair hearing should be removed from the grievance acknowledgement letter, since state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days). **Recommendation:** Language should be clarified as to how state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days). This may mean additionally that the definitions of appeal and grievance, and the processes for both, are clearly defined in writing in the associated policies and procedures for members, providers, and for MCNA staff to ensure that all parties understand the differences between the processes, how to access the process, and how to manage the process. It is imperative that any confusion on this process is clarified among MCNA members, providers, and staff.	
2. Ensure that there is only one level of appeal for members.	This requirement is evidenced within MCNA's practices, however not explicitly stated within the DBPM's policies and procedures. **Recommendation:** Language pertaining to only one level of member appeal should be incorporated into MCNA's policies and procedures and in their member handbook and provider manual.	This recommendation was addressed by the addition of appropriate language pertaining to only one level of member appeal to policies 13.100, 13.200, and 13.203. The revised member handbook was submitted and approved by the MLTC on 6/11/2018. The provider manual was also updated with the recommended revision. The policies and provider manual will be submitted to MLTC for review and approval.
Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual	This requirement is addressed in Policy 13.200 Member Appeals on pages 6 and 7. This requirement is partially addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2, as follows: "Fairness in the review process based on a requirement that internal reviewers have the	The recommendation to update Policy 13.100 with contractual requirement IV.H.1.b.3 has been completed. The policy will be submitted to MLTC for review and approval.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: 1. The denial of service is based on lack of medical necessity. 2. Because of the member's medical condition, the grievance requires expedited resolution. 3. The grievance or appeal involves clinical issues.	necessary and relevant knowledge and expertise to render a decision regarding an appeal or grievance, have not been involved in the initial decision, and have no financial interest in the resolution of the decision." Necessary and relevant knowledge and expertise implies clinical knowledge; however, there is an opportunity to make more transparent. Ten (10) of 10 appeal files met this requirement (demonstrating that the individual completing the appeal review was not the same individual involved in the initial denial decision, and was an appropriate health care professional with expertise in treating the member's condition). It should be noted that within one (1) appeal file, the resolution letter states that the appeal reviewer is a pediatric dentist; however, the appeal reviewer in the case file is listed as a general dentist. Three (3) of four (4) grievance files were not applicable (as they did not pertain to a medical issue). One (1) applicable file met this requirement (demonstrating that the individual addressing member's grievance was a health care professional with appropriate expertise in treating their condition). **Recommendation:** The language in Policy 13.100 Grievances and Appeals Department Overview should reflect contractual requirement IV.H.1.b.3, that the individual addressing the member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: the denial of service is based on lack of medical necessity; because of the member's medical condition, the grievance requires expedited resolution; or the grievance or appeal involves clinical issues.	
The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the	This requirement is addressed in Policy 13.200 Member Appeals on page 3, and in Policy 13.203 Expedited Appeals on page 2. Ten (10) out of 10 appeal files were not applicable, as there were no expedited	The recommendation to revise the expedited appeal acknowledgment letter with required language has been completed.

Substantially Compliant Standard/Substandard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
case of an expedited resolution.	appeals. It should be noted that there were two (2) requests for expedited resolution that were not processed as such, given the criterion for expedited resolution was not met. There was a recommendation made onsite that included a change to the way in which the acknowledgement letter reads in these cases, since it states the DBPM will not approve the member's request, but does not then state "for an expedited (or fast) decision." This may lead to confusion if the member does not carefully read the remainder of the letter, which states the "clinical reviewer determined that the request does not meet the rules for a fast appeal" and that they will "give the member a decision in writing in 30 days." The initial reference to MCNA not approving the request does not apply to the appeal request, but rather the expedited portion of it. **Recommendation:** MCNA should revise the expedited appeal acknowledgment letter in cases where the request does not meet expedited appeal criteria; the DBPM should state that they will not approve the member's request for an expedited (or fast) decision. Adding this additional language (for an expedited (or fast) decision) will help avoid confusion and ensure clarity for the member that their appeal was not necessarily denied, but rather their request for an expedited resolution was.	

MCNA: Managed Care of North America; DBPM: dental benefits program manager; MLTC: Medicaid and Long-Term Care.

Validation of Performance Improvement Projects

MCNA is required to develop and implement PIPs to assess and improve processes of care with the desired result of improving outcomes of care. The projects are focused on the dental health care needs that reflect the demographic characteristics of the MCE's membership, the prevalence of disease, and the potential risks of the disease. PIP topics were discussed and selected in collaboration with NE DHHS and IPRO. An assessment is conducted for each project upon proposal submission, and then again for interim and final re-measurement, using a tool developed by IPRO and consistent with CMS EQR protocols for PIP validation. PIP proposals were submitted on October 31, 2018, ahead of PIP implementation on January 1, 2019. Brief summaries of these PIPs are presented below.

PIP: Annual Dental Visit (ADV)

MCNA proposed a PIP to increase the percentage of members receiving annual dental visits. The PIP employs the modified HEDIS ADV measure, stratified into three age groups: 2–20 years, 1–20 years, and 21+ years. The ADV measure evaluates the percentage of members in the eligible population who saw a dentist during the reporting year. The

baseline period for the PIP was 1/1/18–12/31/18. Analysis of MCNA's baseline data showed the ADV rate for ages 2–20 was 68.2%, the rate for ages 1–20 was 64.9%, and the rate for ages 21+ was 42.6%. The final goal for ages 2–20, 1–20, and 21+ were 69.7%, 67.9%, and 44.1%, respectively.

Member-specific barriers cited by MCNA include members not receiving routine dental visits and instead waiting until they feel pain, lack of oral health knowledge, and language and cultural barriers. A provider-specific barrier identified by MCNA was that PCPs are unaware of MCNA's participating provider network within the proximity of their offices. Member-specific interventions designed to overcome those barriers were text messages to members who have not seen a dentist in the last 6 months, care gap alerts to notify member service representatives that a member is overdue for a dental visit, a member newsletter to provide members with the latest news and developments regarding their oral health, Baby's First Toothbrush and DentalLink programs in partnership with PCPs, and member advocate outreach specialist participation in community outreach events/health fairs.

PIP: Preventive Dental Visit (Pdent)

MCNA proposed a PIP to increase the percentage of members receiving preventive dental visits for members aged 1–20 and members aged 21 and older. The PIP employs two performance indicators: percentage of members who received at least one (1) preventive dental service during the measurement year (two age strata: 1–20 years and 21+ years), and percentage of members who received at least two (2) preventive dental services 6 months apart during the measurement year (age strata: 1–20 years and 21+ years). The baseline period for the PIP was 1/1/18–12/31/18. The baseline rates for the percentage of members who received at least one (1) preventive dental service for the members aged 1–20 and 21+ were 54.6% and 21.0%, respectively. MCNA aims to increase this rate to 58.6% for the 1–20 years age group and to 23.0% for the 21+ age group. The baseline rates for the percentage of members who received at least two (2) preventive dental services for members aged 1–20 and 21+ were 27.1% and 8.4%, respectively. MCNA aims to increase this rate to 30.1% for the 1–20 years age group and to 10.4% for the 21+ age group.

Member-specific barriers cited by MCNA include members not receiving routine dental visits and instead waiting until they feel pain, lack of oral health knowledge, and language and cultural barriers. A provider-specific barrier that was identified by MCNA was that primary care dentists (PCDs) are not taking advantage of minimally applying fluoride when members are seeking treatment services only. A plan-specific barrier that MCNA faces is the lack of medical, diagnostic data that indicate the member, as a function of medical chronicity, is at higher risk for oral health disease; MCNA has no access to medical, diagnostic data for its members. Member-specific interventions cited by MCNA include text messages to members who have not seen a dentist in the last 6 months and for members in need of a recall visit, care gap alerts to notify member service representatives that a member is overdue for a dental visit, Baby's First Toothbrush program, and a member newsletter to provide members with the latest news and developments regarding their oral health. A provider-specific intervention cited by MCNA was to increase the fee for fluoride by $5 to encourage increased utilization. To overcome the plan-specific barrier, MCNA will provide training on its DentalLink program for high-volume, medical, participating primary care provider (PCP) practices on how the PCPs should leverage the DentalLink referral, in view of this high-risk population, to bridge coordination of medical and oral healthcare and the positive properties this synergy will have on the member's overall health.

Nebraska Quality Strategy

Nebraska's Quality Strategy (originally approved in July 2003) was last re-written in 2017 to address the change to an integrated managed care program (Heritage Health) that covers physical health care, behavioral health care, and pharmacy benefits, as well as the addition of MCNA to cover dental benefits for Medicaid beneficiaries. As part of its Quality Strategy, the state requires that all Managed Care Entities have methods to determine the quality and appropriateness of care for all Medicaid enrollees under the Nebraska Medicaid contracts.

DHHS assesses the quality and appropriateness of care through multiple processes that comprise a comprehensive system of oversight:

- Quarterly reporting of provider accessibility analyses, monitoring of timely access standards, grievances and appeals process compliance, UM monitoring, monitoring results of service verification, monitoring out of network referrals, and case management results.
- Annual reporting of DHHS-selected performance measure results and trends related to quality of care, service utilization, and member and provider satisfaction.
- Annual reporting of PIP data and results.
- Annual, external independent reviews of the quality outcomes, timeliness of and access to the services covered by the MCE.
- Annual state-conducted onsite operational reviews that include validation of reports and data previously submitted by the MCE, and in-depth review of areas that have been identified as potentially problematic.
- DHHS requires MCEs to attend quarterly Quality Management Committee meetings, during which data and information designed to analyze the objectives of the Quality Strategy are reviewed. The Quality Management Committee recommends actions to improve quality of care, access, utilization, and client satisfaction, and to review the results of the PIPs and recommend future PIP topics. The Quality Management Committee also reviews the state's overall Quality Strategy and makes recommendations for improvement.

The full version of Nebraska's Quality Strategy can be found on the Department of Health and Human Services website: http://dhhs.ne.gov/medicaid/Documents/Quality Strategy for Heritage Health and the Medicaid Dental Benefit Program 2017.pdf .

Efforts to Reduce Healthcare Disparities

As part of this year's technical report, IPRO discussed current efforts to reduce healthcare disparities with the state and MCNA. A summary of the information provided follows.

The objectives of the Nebraska Medicaid Managed Care Program are to improve access to quality care and services, improve client satisfaction, reduce racial and ethnic health disparities, and reduce/prevent inappropriate/unnecessary utilization. Per the DHHS Division of Medicaid and Long-Term Care's Quality Strategy, DHHS requires MCEs to maintain an information system that includes the capability to collect data on client and provider characteristics, identify methods to assess disparities in treatment among disparate races and ethnic groups, and to correct those disparities.

MCEs must have a searchable database that includes network providers and facilities with information regarding race/ethnicity and languages. MCEs assess the cultural, ethnic, racial, and linguistic composition of their networks against the needs and preferences of enrollees and include provider search options for language spoken and ethnicity.

DHHS currently provides client data related to race, ethnicity, and primary language through the monthly eligibility file transmitted to the MCEs. It is expected that the MCEs will use these data to promote delivery of services in a culturally competent manner and to reduce racial and ethnic health disparities for enrollees.

A comprehensive description of DHHS efforts to reduce healthcare disparities can be found in their Quality Strategy (link provided in **Nebraska Quality Strategy**).

MCNA implemented a community outreach and education plan. MCNA has a member advocate outreach specialist (MAOS) dedicated to the state of Nebraska. This individual is responsible for creating collaborative relationships with

various community organizations in order to educate and advocate for MCNA's Nebraska Medicaid Dental Program members.

MCNA's MAOS focuses outreach efforts to organizations that serve typically underserved areas and individuals (individuals with special needs, rural areas, and tribal organizations). MCNA works with these organizations to educate members about proper oral health, as well as benefits they have through the Nebraska Medicaid Dental program. MCNA also works with these community partners to assist uninsured people with locating resources, from medical to dental to financial.

Corporate-level activities to date include:

- Providing a MAOS dedicated solely to the Nebraska Medicaid Dental Program;
- Providing sponsorship for member and provider events; and
- Enhancing cultural competency training and resources.

At the local level, MCNA has:

- Worked with various school districts to help ensure children have needed back-to-school supplies by participating in back-to-school events;
- Distributed more than 2,500 educational flyers, dental kits, and other oral hygiene products at health fairs and presentations;
- Attended meetings with various health care management organizations to help plan community events to provide dental education to the public;
- Participated in health fairs and other community events sponsored by federally qualified health centers (FQHCs) and Indian health care providers (IHCPs);
- Worked with Special Olympics to provide education to children and adults with special needs, as well as their caregivers;
- Set up tables at several health district women, infants and children (WIC) clinics to provide information regarding the importance of proper oral hygiene during pregnancy and for babies;
- Attended food pantry days with the Salvation Army; and
- Assisted uninsured people with locating free or reduced-cost dental care.

MCNA identified and acted upon several opportunities, including:

- **Outreach to Pregnant Women:** MCNA set up educational tables at several WIC clinics throughout the state to provide education to pregnant women or women of young children.
- **Sponsorships:** MCNA sponsored several events such as the Nebraska Dental Association Annual Session, One World (FQHC) Community Event, and the World Oral Health Day event. MCNA provided education to members and providers at these events.

Other organizations that MCNA partnered with in terms of education and/or sponsorship included: Omaha YMCA Downtown, WellCare, Clinic with a Heart, Urban Indian Health Clinic, Big Brothers Big Sisters, Salvation Army, and the Center for People in Need.

MCNA continues to identify organizations that work with underserved populations. MCNA will continue to collaborate with previously identified community partners while seeking new community organizations to work with in the coming year. As part of these collaborative efforts, MCNA will work with these organizations to organize and plan community events, provide presentations to members and staff, as well as work to identify barriers to care.

Appendix A: Compliance Monitoring

Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358 delineate that a review of an MCE's compliance with standards established by the state to comply with the requirements of § 438 Subpart E is a mandatory EQR activity. Further, this review must be conducted within the previous three (3)-year period, by the state, its agent, or the EQRO.

NE DHHS annually evaluates the MCE's performance against contract requirements and state and federal regulatory standards through its EQRO contractor, as well as by an examination of each MCE's accreditation review findings. As permitted by federal regulations, in an effort to prevent duplicative review, NE DHHS utilizes the accreditation findings, where determined equivalent to regulatory requirements.

In order to determine which regulations must be reviewed annually, IPRO performs an assessment of the MCE's performance on each of the federal managed care regulations over the prior three (3)-year period. Results of both the EQRO reviews and accreditation survey are examined. The following guidelines are used to determine which areas are due for assessment:

- regulations for which accrediting organization standards have been cross-walked and do not fully meet equivalency with federal requirements;
- regulations that are due for evaluation, based on the three (3)-year cycle;
- regulations for which the MCE received less than full compliance on the prior review by either the EQRO or accrediting organization. Please note that the prior review in this case consisted of the MCO's readiness review;
- state- and contract-specific requirements beyond the federal managed care regulatory requirements;
- areas of interest to the state, or noted to be at risk by either the EQRO and/or state;
- note that Quality Management: Measurement and Improvement – Quality Assessment and Performance Improvement (QAPI) (42 CFR 438.240) is assessed annually, as is required by federal regulations.

The annual compliance review for September 2017–March 2018, conducted in May 2018, addressed contract requirements and regulations within the following categories:

- Provider Network
- Provider Services
- Member Services and Education
- Quality Management
- Utilization Management
- Subcontracting
- Grievances and Appeals

Data collected from each MCE submitted pre-onsite, during the onsite visit, or in follow-up was considered in determining the extent to which the MCE was in compliance with the standards. Further, descriptive information regarding the specific types of data and documentation reviewed is provided in **Description of Data Obtained**, below, and in **Compliance Monitoring** in this report.

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., substandards). The tools include the following:

- statement of federal regulation and related federal regulations;
- statement of state regulations;
- statement of state and MCE contract requirement(s);
- suggested evidence;
- reviewer determination;

- prior results (based on Readiness Review);
- descriptive reviewer findings and comments related to findings; and
- MCE 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 **Table A.1**.

Table A.1: Standard Compliance Determinations

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

MCE: managed care entity.

The list of elements due for review and the related review tools were shared with NE DHHS and each MCE.

Pre-onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports. Additional documents were requested to be available for the onsite visit, such as reports and case files.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing of grievances received by the MCE for a selected time period; or, for care coordination, a listing of members enrolled in care management during a selected time period. From these listings, IPRO selected a random sample of files for review onsite.

Additionally, IPRO began its "desk review" or offsite review when the pre-onsite documentation was received from the MCEs. Prior to the review, a notice was sent to the MCEs including a confirmation of the onsite dates, an introduction to the review team members, the onsite review agenda, and an overall timeline for the compliance review activities.

Onsite Activities – The onsite review commenced with an opening conference, where staff was introduced, and an overview of the purpose and process for the review including the onsite agenda was provided. Following the opening conference, IPRO conducted review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walk-throughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed, and the next steps in the review process.

Description of Data Obtained

As noted in **Pre-onsite Activities**, in advance of the review, IPRO requested documents relevant to each standard under review to support each MCE's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI program description, work plan, and annual evaluation; member and provider handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow up. Additionally, as reported above under **Onsite Activities**, staff interviews and demonstrations were conducted during the onsite visit. Supplemental

documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the 2018 review is included in **Compliance Monitoring** in this report.

Data Aggregation and Analysis

Post-onsite Activities – Following the onsite review, the MCEs were provided with a limited time period to submit additional documentation while IPRO prepared the preliminary review findings. As noted earlier, each standard reviewed was assigned a level of compliance ranging from full compliance to non-compliance. The review determination was based on IPRO's assessment and analyses of the evidence presented by the MCE. For standards where an MCE was less than fully compliant, IPRO provided in the review tool a narrative description of the evidence reviewed, and reason for non-compliance. Each MCE was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. IPRO reviewed any responses submitted by the MCE and made final review determinations.

Appendix B: Validation of Performance Improvement Projects

Objectives

Medicaid MCEs implement PIPs to assess and improve processes of care, and as a result improve outcomes of care. The goal of PIPs is to achieve significant and sustainable improvement in clinical and nonclinical areas. A mandatory activity of the EQRO is to review PIPs for methodological soundness of design and conduct, and report to ensure real improvement in care and confidence in the reported improvements.

PIPs were reviewed according to the CMS protocol described in the document "Validating Performance Improvement Projects." The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following 10 elements:

- review of the selected study topic(s) for relevance of focus and for relevance to the MCE's enrollment;
- review of the study question(s) for clarity of statement;
- review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the PIP;
- review of the identified study population to ensure it is representative of the MCE enrollment and generalizable to the MCE's total population;
- review of sampling methods (if sampling used) for validity and proper technique;
- review of the data collection procedures to ensure complete and accurate data was collected;
- assessment of the improvement strategies for appropriateness;
- review of the data analysis and interpretation of study results;
- assessment of the likelihood that reported improvement is "real" improvement; and
- assessment of whether the MCE achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable. Note that, since the PIPs were initiated in 2018, a formal review of findings was not applicable for any of the projects represented within this report.

Technical Methods of Data Collection

The methodology for validation of the PIPs was based on the CMS protocol, "Validating Performance Improvement Projects." Each PIP was reviewed using this methodology upon proposal submission. Upon first re-measurement and each re-measurement thereafter, each of the 10 protocol elements is considered.

Description of Data Obtained

Each PIP was validated using the MCE's PIP project reports, and in collaboration with DHHS's data and analytics team (to validate statewide, averages compare state-collected MCE rates against what the MCEs reported in their proposals). Data obtained at the proposal stage included baseline, benchmark, and goal rates.

Data Aggregation and Analysis

Each applicable protocol element necessary for a valid PIP is documented within this report. Because only PIP proposals were available for evaluation in MY 2018, analysis included review of the study topic, questions, indicators, target population, and data collection procedures. Sampling was not applicable within any of the PIPs.

Upon final reporting, a determination will be made as to the overall credibility of the results of each PIP, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility of the PIP results is at risk.
- The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution. Processes that put the conclusions at risk will be enumerated.
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk will be enumerated.