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 2018 – 2019
April 2020

IPRO
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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 "[t]he 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 three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.358, the three 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.

Validation of Performance Measures (PMs) – IPRO reviewed performance measures reported to Nebraska Division of Medicaid and Long-Term Care (MLTC), to validate the accuracy of rates.

CMS defines *validation* in the Final Rule in 42 CFR 438.320 as "[t]he 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 2019, 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, performance measurement, and findings from six of the seven compliance domains: Member Services and Education, 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 68.1%, 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 performance indicators: percentage of members who received at least one 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 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 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+ years age group. The baseline rates for the percentage of members who received at least two preventive dental services for members aged 1–20 years and 21+ years 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+ years age group.

Interim results for performance indicators and quarterly intervention tracking measure data for CY 2019 will be available in April 2020.

Performance Measurement

As required by federal Medicaid external quality review (EQR) regulations and requirements, under contract with DHHS, as the EQRO, IPRO was tasked with validating the reliability and validity of the dental benefits program manager (DBPM)'s reported PM rates. The purpose of the validation was to:

- evaluate the accuracy of the Medicaid PMs reported by the DBPM; and
- determine the extent to which the Medicaid-specific PMs calculated by the DBPM followed the specifications established by MLTC and/or the performance measure stewards.

IPRO conducted validation of MCNA's reported performance measures in late 2019 for MY 2018. This included review of member-level detail files of the eligible population for each applicable measure and review of the source code that MCNA utilized to generate and calculate the numerator, denominator, and rate for accuracy and reasonability according to the measure specifications. MCNA passed validation for all applicable performance measures.

In future performance measurement validation cycles, IPRO recommends that MCNA:

- include comments in the source code script and create a separate source code script for each measure, or clearly indicate which performance measure each piece of logic in the code is referencing.

Compliance Review

MCNA received a designation of full compliance for Provider Network, Provider Services, Subcontracting, and Utilization Management. The DBPM received a designation of partial compliance for Grievances and Appeals (note that there were no partially compliant standards related to quality for grievances and appeals), Member Services and Education, and Quality Management. MCNA received a designation of non-compliance for five elements under Quality Management:

- Of the 7 standards reviewed for Member Services and Education, 5 were fully compliant and 2 were partially compliant. The following details findings from the review of these partially compliant standards:

- Although members are informed that they can call the member hotline if they want to know more about the structure and operations of MCNA, it is not explicitly indicated that members can request reports of transactions between the DBPM and parties in interest provided to the state.
- MCNA confirmed that they do not have bi-directional communication in their public website or member portal. Members are directed to call the member hotline, which includes TTY options. However, there is no in-browser live or delayed bi-directional communication for members. MCNA also confirmed that they rely on members to use keyboard shortcuts to increase font size in their browser for viewing the DBPM's website. However, this does not resolve the problem that some members may not be able to see the pre-set font size on their browser to be able to utilize the FAQ or that some members might not have sufficient computer literacy to know which type of browser or device they are using, which would affect the shortcuts they need to utilize.

- Of the 21 standards reviewed for Quality Management, 13 standards were fully compliant, 2 were partially compliant, and 5 were non-compliant. One (1) standard was not applicable. The following details findings from the review of the partially compliant and non-compliant standards for the domain of quality:
  - Care Management activities were not summarized and evaluated in the QI Program Evaluation.
  - All provider satisfaction surveys were conducted in-person by a provider relations representative, following their site visit. Not all provider offices were targeted, and this may bias results.
- Non-compliant standard(s)
  - MCNA is not utilizing a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey or methodology that is consistent with CAHPS.
  - Survey results were reported to MLTC; however, they were not reflective of CAHPS.
  - Member services representatives attempt to conduct a member satisfaction survey on each inbound call received. This methodology is not consistent with statistically valid random sampling of members enrolled in the dental benefits program manager (DBPM).
  - The DBPM did not follow CAHPS or CAHPS-like methodology; thus, the validity and reliability of survey results should be interpreted with caution.
  - Although MCNA conducts member satisfaction surveys across various states, it is not possible to assess results against national and state benchmark standards because the CAHPS survey was not utilized.

In the domain of quality, IPRO recommends that MCNA:

- include functional buttons on their website that members can click to increase/decrease font easily, without having to utilize device/platform-specific keyboard shortcuts. The DBPM should also implement a website function for members to initiate bi-directional communication, either as live chat or as an in-browser message/email section.
- provide the new member handbook, including the requirement that members can request reports of transactions between the DBPM and the state in the next review cycle, upon MLTC approval.
- ensure that all care management activities are summarized and evaluated in the DBPM's QI Program evaluation.
- explore alternate modes of provider satisfaction survey distribution in order to reach more practitioners and limit the inherent bias associated with in-person survey methodology following a site visit.
- utilize the dental CAHPS survey or a methodology that is consistent with this survey instrument in order to adequately assess the quality and appropriateness of care for members.
- align their survey process with CAHPS to ensure a statistically valid random sample is utilized and that responses are anonymous. Further, the DBPM should engage a vendor to distribute the survey and collect responses.
- in order to be consistent with CAHPS methodology, should ensure a statistically random sample is drawn, based on members who have had a dental visit with an MCNA provider.
- in order to ensure survey results are valid and reliable, utilize CAHPS or CAHPS-like methodology, and results should be stratified by county and include an overall statewide average; and
- evaluate their survey methodology and ensure it aligns with CAHPS. The DBPM should have a procedure in place that outlines how they will evaluate survey results to ensure appropriate statistical analysis is employed in order to target improvement efforts.

Timeliness

The timeliness domain includes findings from two of the seven compliance domains: Utilization Management, and Grievances and Appeals. There were no partially compliant standards related to timeliness for Utilization Management.

Compliance Review

- Of the 7 standards reviewed for Grievances and Appeals, 6 standards were fully compliant and 1 was partially compliant. The partially compliant standard was related to timeliness. The following details the finding from the review of the partially compliant standard:
  - Of the 10 appeals files reviewed for this requirement, 2 files were not applicable because they were expedited appeals, 1 file did not meet the requirement, and the remaining 7 files met the requirement.

In the domain of timeliness, IPRO recommends that MCNA:

- review appeals policies and procedures for timeliness with staff to ensure that all standard appeals received are acknowledged within 10 calendar days of receipt.

Access

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

Compliance Review

MCNA received a designation of full compliance for Provider Network.

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

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 240,000 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. Beginning July 2019, non-emergency medical transportation (NEMT) services were carved into the Heritage Health Program, thereby allowing the MCOs to further integrate and coordinate care for their members.

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: Managed Care of North America.

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 2019, MCNA's membership totaled 241,693.

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

- families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups;
- children, adults, and related populations who are eligible for Medicaid due to blindness or disability;

- Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population;
- low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI (CHIP);
- 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;
- 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;
- women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters);
- Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined; and
- members eligible during a period of presumptive eligibility.

DHHS currently contracts with vendors to perform the following services for Heritage Health:
- physical health managed care services,
- behavioral health managed care services,
- enrollment broker services,
- external quality review services,
- actuarial services, and
- 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.

The goals and objectives for the Heritage Health Program directly reflect the Quadruple Aim of improving member experience of care, provider experience, the health of populations, and reducing the per-capita cost of health care. MLTC seeks to achieve the following goals under this integrated physical and behavioral health system:
- 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.

In terms of oral health, MLTC seeks to achieve the following goals:

- improved access to routine and specialty dental care;
- improved coordination of care;
- better dental health outcomes;
- increased quality of dental care;
- outreach and education to promote dental health;
- increased personal responsibility and self-management; and
- overall savings to the Nebraska Medicaid program by preventing treatable dental conditions from becoming costly medical conditions.

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 2019, IPRO conducted a compliance monitoring site visit, validation of performance measures, 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 – C** 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 12/2019)	241,693
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 opportunities for improvement related to quality, timeliness, and access. The findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Validation of Performance Measures, and Validation of Performance Improvement Projects).

Compliance Monitoring

This subpart of the report presents the results of MCNA's compliance with regulatory standards and contract requirements for April 1, 2018–March 31, 2019. The review is based on information derived from IPRO's conduct of the annual regulatory compliance review, which took place in May 2019. 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 4/1/18–3/31/2019), 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)									Compliance 2019 (Measurement Period 4/1/18–3/31/19)								
	n =	Full		Partial[1]		Non-compliant		Not Applicable		n =	Full		Partial[1]		Non-compliant		Not Applicable	
Grievances and Appeals	38	34	89%	4	11%	0	0%	0	0%	7	6	86%	1	14%	0	0%	0	0%
Member Services and Education	51	47	92%	4	8%	0	0%	0	0%	7	5	71%	2	29%	0	0%	0	0%
Provider Network	42	42	100%	0	0%	0	0%	0	0%	18	18	100%	0	0%	0	0%	0	0%
Provider Services	3	3	100%	0	0%	0	0%	0	0%	13	13	100%	0	0%	0	0%	0	0%
Quality Management	28	20	71%	0	0%	0	0%	8	29%	21	13	62%	2	10%	5	24%	1	5%
Subcontracting	4	4	100%	0	0%	0	0%	0	0%	2	1	50%	0	0%	0	0%	1	50%
Utilization Management	48	45	94%	2	4%	0	0%	1	2%	16	16	100%	0	0%	0	0%	0	0%

[1] Minimal compliance and substantial compliance deemed categories have been collapsed into the partial compliance category, starting in 2019. Categories have been collapsed in this table for 2018 for consistency.

Green shading: full compliance; yellow shading: partial compliance; pink shading: non-compliant; gray shading: not applicable.

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, MCP program reports on appeals and grievances, Quality Improvement (QI) Committee minutes, and staff interviews.

A total of 7 standards were reviewed; 6 standards were fully compliant and 1 was partially compliant. This partially compliant grievances and appeal standard is presented in **Table 4**.

Table 4: Grievances and Appeals – Partially Compliant Standard

Partially Compliant Standard	Findings and Recommendations for Improvement	MCNA Response and Action Plan
Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	Of the 10 appeals files reviewed for this requirement, 2 files were not applicable because they were expedited appeals, 1 file did not meet the requirement, and the remaining 7 files met the requirement. **Recommendation:** MCNA should review appeals policies and procedures for timeliness with staff to ensure that all standard appeals received are acknowledged within 10 calendar days of receipt.	Staff has been trained to ensure all standard appeals received are acknowledged within 10 calendar days of receipt (MCNA provided a sign-in sheet as evidence of this training).

MCNA: Managed Care of North America.

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, primary care provider (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 7 standards were reviewed; 5 were fully compliant and 2 were partially compliant. These partially compliant member services and education standards are presented in **Table 5**.

Table 5: Member Services and Education – Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
The member handbook must include 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	Parts a through d of this requirement are addressed in the member handbook on page 34. Although members are informed that they can call the member hotline if they want to know more about the structure and operations of MCNA, it is not explicitly indicated that members can request reports of transactions between the DBPM and parties in interest provided to the state. **Recommendation:** The DBPM should provide the new member handbook, including the requirement that members can request these	The member handbook has been updated and was submitted to MLTC for review and approval on May 13, 2019.

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the state.	reports, in the next review cycle upon MLTC approval.	
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 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.	MCNA confirmed that they do not have bi-directional communication in their public website or member portal. Members are directed to call the member hotline, which includes TTY options. However, there is no in-browser live or delayed bi-directional communication for members. MCNA also confirmed that they rely on members to use keyboard shortcuts to increase font size in their browser for viewing the DBPM's website. The Frequently Asked Questions (FAQ) section, #12, describes how members can use these shortcuts to increase font size. However, this does not resolve the problem that some members may not be able to see the pre-set font size on their browser to be able to utilize the FAQ or that some members might not have sufficient computer literacy to know which type of browser or device they are using, which would affect the shortcuts they need to utilize. **Recommendation:** MCNA should include functional buttons on their website that members can click to increase/decrease font easily without having to utilize device/platform-specific keyboard shortcuts. The DBPM should also implement a website function for members to initiate bi-directional communication, either as live chat or as an in-browser message/email section.	MCNA's IT team is currently evaluating options for the bi-directional communication for our members through our websites. The addition of functional buttons to increase font size will be implemented by the team within the next 45 days.

MCNA: Managed Care of North America; DBPM: dental benefits program manager; CFR: Code of Federal Regulations; MLTC: Medicaid and Long-Term Care; TTY: teletype; FAQ: Frequently Asked Questions; IT: information technology.

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 18 standards 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 13 standards were reviewed; all were fully compliant.

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 21 standards were reviewed; 13 were fully compliant, 2 were partially compliant, 5 were non-compliant, and 1 was deemed not applicable. Partially compliant quality management standards are presented in **Table 6**. Non-compliant quality management standards are presented in **Table 7**.

Table 6: Quality Management – Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
QAPI Committee Responsibilities The committee must: a. Meet on a quarterly basis. b. Direct and review Quality Improvement (QI) activities. c. Ensure that QAPI activities are implemented throughout the DBPM. d. Review and suggest new and or improved QI activities. e. Direct task forces and committees to review areas of concern in the provision of healthcare services to members. f. Designate evaluation and study design procedures. g. Conduct individual dental home and dental home practice quality performance measure profiling. h. Report findings to appropriate executive authority, staff, and departments in the DBPM. i. Direct and analyze periodic reviews of members' service utilization patterns. j. Maintain minutes of all committee and subcommittee meetings and submit a summary of the meeting minutes to MLTC with other quarterly reports. k. Report an evaluation of the impact and effectiveness of the	This requirement is partially addressed in MCNA's QI Program Description and in the QAPI Program Evaluation. The Quality Improvement Committee (QIC) oversees the QI Program and assesses its effectiveness. Evidence of quarterly meetings is apparent in the meeting minutes that were submitted. Requirement k that the DBPM must "[r]eport an evaluation of the impact and effectiveness of the QAPI Program to MLTC annually. This report must include, but is not limited to, all care management activities" is not evidenced in the evaluation that was submitted. On site, the DBPM indicated that their members are referred to Case Management (CM) through their MCO. All requests are sent to one centralized email address at MCNA, and then assigned to CM staff. All departments are trained to field calls received by the MCOs as they relate to member referrals into CM. Once a referral is received, it is the goal of MCNA to contact the member within 48 hours, unless it is an emergency request (in which case, the member is contacted sooner). MCNA's CM coordinators call members after receiving the referral and a dental health assessment is completed. If the DBPM is unsuccessful at contacting the member at initial outreach, they call twice within a 2-week period at different times of the day. After no contact via phone, a letter is sent to the member's home. If a member has	We agree with this statement and will include additional detail in future evaluations.

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
QAPI Program to MLTC annually. This report must include, but is not limited to, all care management activities.	special health care needs, they will remain in CM; otherwise, each case is closed following receipt of needed services. Quarterly meetings take place with designated MCO CM staff, and MLTC is copied on all email communications between MCNA and MCO CM staff. **Recommendation:** MCNA should ensure that all care management activities are summarized and evaluated in their QI Program Evaluation.	
The DBPM must submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	Per the QI Work Plan, there were 137 Provider Satisfaction surveys completed in CY 2018, with an overall satisfaction rate of 93.88%, exceeding MCNA's goal of 80%. All surveys were conducted in person by provider relations representatives, following their site visit. Not all provider offices were targeted. This may bias results. On site, discussion took place that explained the biases that exist around in-person surveying, as well as the limitations associated with mailed surveys (in terms of low response rate). **Recommendation:** The DBPM should explore alternate modes of Provider Satisfaction Survey distribution in order to reach more practitioners and limit the inherent bias associated with in-person survey methodology following a site visit. Mailed surveys allow for anonymity, and low response rate can be mitigated by sending out several waves of the survey, supplying an incentive for completion, and/or communicating the importance of the survey in provider newsletters, mailings, etc.	We will evaluate alternate survey delivery options.

MCNA: Managed Care of North America; QAPI: Quality Assessment Performance Improvement; QI: Quality Improvement; DBPM: dental benefits program manager; MLTC: Medicaid and Long-Term Care; QIC: Quality Improvement Committee; CM: Case Management; MCO: managed care organization.

Table 7: Quality Management – Non-compliant Standards

Non-compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
The DBPM must conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the	MCNA is not utilizing either a CAHPS survey or methodology that is consistent with CAHPS. **Recommendation:** MCNA should utilize the dental CAHPS survey or a methodology that is	A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid

Non-compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
quality and appropriateness of care to members each contract year. The most current CAHPS DBPM Survey for Medicaid-enrolled individuals must be used and include: 1. Getting Needed Care 2. Getting Care Quickly 3. How Well Providers Communicate 4. DBPM Customer Service 5. Global Ratings Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.	consistent with this survey instrument in order to adequately assess the quality and appropriateness of care for members. The domains outlined in the requirement should be reflected in this survey and mirror the questions (and response scale) utilized in the CAHPS survey. The scale used to record member responses should be revised to reflect the CAHPS scale. The scale MCNA is currently using is skewed in a positive/favorable direction because it assigns scores to Likert values and calculates performance based on those scores. For instance; a satisfaction level of 1 is equal to a score of 60; 2 is 75; 3 is 83; 4 is 95; and 5 is 100. The aggregate of these scores is difficult to evaluate because the difference between each level varies (15 units from 1 to 2; 8 units from 2 to 3; 12 units from 3 to 4; and 5 units from 4 to 5). Upon aggregation of survey findings, results will be skewed in a favorable direction (given the small difference between the 4th and 5th levels, and because the lowest possible score is 60, as opposed to 0).	limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members (https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html). We will wait on further direction since this population doesn't have a corresponding survey.
Survey results and a description of the survey process must be reported to MLTC separately for each required CAHPS survey.	Survey results were reported to MLTC; however, they were not reflective of CAHPS. **Recommendation:** MCNA should align their survey process with CAHPS to ensure a statistically valid random sample is utilized and that responses are anonymous. Further, the DBPM should engage a vendor to distribute the survey and collect responses.	A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members (https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html). We will wait on further direction since this population doesn't have a corresponding survey.
The survey must be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.	Member services representatives attempt to conduct a member satisfaction survey on each inbound call received. This methodology is not consistent with statistically valid random sampling of members enrolled in the DBPM. **Recommendation:** In order to be consistent with CAHPS methodology, MCNA should ensure a statistically random sample is drawn, based on members who have had a dental visit with an MCNA provider.	A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members (https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html).

Non-compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
		We will wait on further direction since this population doesn't have a corresponding survey.
The surveys must provide valid and reliable data for results statewide and by county.	The DBPM did not follow CAHPS or CAHPS-like methodology; thus, the validity and reliability of survey results should be interpreted with caution. **Recommendation:** In order to ensure survey results are valid and reliable, MCNA should utilize CAHPS or CAHPS-like methodology. Results should be stratified by county, and include an overall statewide average.	A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. (https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html). We will wait on further direction since this population doesn't have a corresponding survey.
Analysis must provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	Although MCNA conducts member satisfaction surveys across various states, it is not possible to assess results against national and state benchmark standards because the CAHPS survey was not utilized. **Recommendation:** MCNA should evaluate their survey methodology and ensure it aligns with CAHPS. The DBPM should have a procedure in place that outlines how they will evaluate survey results to ensure appropriate statistical analysis is employed in order to target improvement efforts.	A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members (https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html). We will wait on further direction since this population doesn't have a corresponding survey.

MCNA: Managed Care of North America; DBPM: dental benefits program manager; CAHPS: Consumer Assessment of Healthcare Providers and Subsystems; MLTC: Medicaid and Long-Term Care.

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 MCP 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 2 standards / sub-standards were reviewed; 1 standard was fully compliant and 1 standard was 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 16 standards / sub-standards were reviewed; all were fully compliant.

Validation of Performance Measures

A goal of the Medicaid program is to improve the health status of Medicaid recipients. Statewide health care outcomes, health indicators, and goals have been designed by the Nebraska Division of Medicaid and Long-Term Care (MLTC) under the Department of Health and Human Services (DHHS). Federal Medicaid Managed Care (MMC) regulations 438.330 (C)(1) and (C)(2), Performance Measurement, require that the Medicaid managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) measure and report to the state their performance, using standard measures required by the state and/or submit to the state data that enable the state to measure the managed care entities' (MCEs') performance. As a result, a requirement of the Nebraska Medicaid PAHP contract is the annual reporting of performance measures (PMs). These PMs, selected by MLTC, include the Healthcare Effectiveness Data and Information Set (HEDIS®), Dental Quality Alliance (DQA), Centers for Medicare and Medicaid Services (CMS), and state-specific PMs, which are based upon the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Together, the measures address the access to, and timeliness and quality of dental care provided for children younger than 20 years of age enrolled in managed care with a focus on preventive care and treatment.

During measurement year (MY) 2018 and under contract to DHHS, MCNA Dental, Nebraska's dental benefits program manager (DBPM), provided dental services to Medicaid recipients in Nebraska across all 93 counties. Managed care services for physical and behavioral health for these recipients are furnished by the MCOs in the state. In order to assess the effectiveness of dental care, the DBPM is required to report performance measures, which must be submitted to MLTC at least quarterly (administrative PMs) or annually (clinical PMs).

As required by federal Medicaid external quality review (EQR) regulations and requirements, under contract with DHHS, as the external quality review organization (EQRO), Island Peer Review Organization (IPRO) was tasked with validating the reliability and validity of the DBPM's reported PM rates. The purpose of the validation was to:

- evaluate the accuracy of the Medicaid PMs reported by the DBPM; and
- determine the extent to which the Medicaid-specific PMs calculated by the DBPM followed the specifications established by MLTC and/or the performance measure stewards.

IPRO conducted validation of MCNA's reported performance measures in late 2019 for MY 2018. This included review of member-level detail files of the eligible population for each applicable measure and review of the source code that MCNA utilized to generate and calculate the numerator, denominator, and rate for accuracy and reasonability according to the measure specifications. MCNA passed validation for all applicable performance measures. In future validation cycles, IPRO recommends that MCNA include comments in the source code script and create a separate source code script for each measure, or clearly indicate which performance measure each piece of logic in the code is referencing.

IPRO will conduct the performance measure validation for reporting year 2020 (MY 2019) for the DBPM in Q4 2020.

Table 8 presents the measures validated descriptions of each measure and the calculated rates for each measure.

Table 8: Nebraska Medicaid 2019 Performance Measures MCNA – RY 2019

Nebraska Medicaid 2019 Performance Measures MCNA – RY 2019					
Measure Name	**Admin (A)/ Hybrid (H)**	**Measure Definition**	**RY 2019 Member Denominator**	**RY 2019 Member Numerator**	**RY 2019 Rate**
Child Core Measure					
Preventive Dental Services (Pdent)	A	The percentage of members under the age of 21 years who received at least one preventive dental service by or under the supervision of a dentist during the measurement year.	190,570	99,095	52%
HEDIS Measure					
Annual Dental Visit (ADV)	A	The percentage of members 2–3 years of age who had at least one dental visit during the measurement year.	16,485	8,662	53%
		The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.	24,577	17,938	73%
		The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.	32,271	24,799	77%
		The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.	29,738	20,962	70%
		The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.	22,304	13,683	61%
		The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.	2,173	988	45%
		Total ADV (2–20 years of age).	127,548	87,032	68%
Dental Quality Alliance Measures					
UTL-CH-A	A	The percentage of enrolled children under 21 years of age who received at least one dental service within the reporting year.	171,252	100,421	59%
TRT-CH-A	A	The percentage of enrolled children under 21 years of age who received a treatment service within the reporting year.	171,252	38,241	22%
OEV-CH-A	A	The percentage of enrolled children under 21 years of age who received a comprehensive oral evaluation within the reporting year.	171,252	93,993	55%
CCN-CH-A[1]	A	The percentage of children under 21 years of age enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	N/A	N/A	N/A

[1] CCN-CH-A is not applicable for reporting year (RY) 2019 (measurement year [MY] 2018), given two consecutive years' enrollment criteria and MCNA's operational start date of October 2017.

MCNA: Managed Care of North America; RY: reporting year; A: admin; H: hybrid; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable.

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 reviewed and approved in April 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.

Table 9: Baseline Rate vs Goal Rate of Members who had at Least One Dental Visit

Indicator	Baseline Rate	Target Goal
Annual Dental Visit – ages 1-20	64.9%	67.9%
Annual Dental Visit – ages 2-20	68.1%	69.6%
Annual Dental Visit – ≥ 21 years of age	42.6%	44.1%

As shown in **Table 9**, the baseline rate for the ADV measure for ages 2–20 was 68.1%, 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 69.6%, 67.9%, and 44.1%, respectively.

To reach and surpass each target goal, MCNA has identified barriers to address with PIP interventions. 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. 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 program, and member advocate outreach specialist participation in community outreach events/health fairs. These interventions began on 1/1/19 and will continue through until the end of the PIP in 2021.

A provider-specific barrier identified by MCNA was that PCPs are unaware of MCNA's participating provider network in the proximity of their offices. MCNA has implemented the Dental Link Program to address this barrier, which serves as a means for providers to refer members for dental services and provides members with locations closest to the PCP's office for dental services. This intervention began on 1/1/19 and will continue through until the end of the PIP in 2021.

Interim results for CY 2019 for the ADV measure and all intervention tracking measures will be available in April 2020 and incorporated into next year's annual technical report.

PIP: Preventive Dental Visit (Pdent)

MCNA proposed a PIP to increase the percentage of members receiving preventive dental visits for members aged 1–20 years and members aged 21 years and older. The PIP employs two performance indicators: percentage of members who received at least one 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 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.

Table 9a: Baseline Rate vs Goal Rate of Members Receiving Preventive Dental Visits

Indicator	Baseline Rate	Target Goal
One Preventive Dental Service, ages 1–20 years	54.6%	58.6%
One Preventive Dental Service, ≥ 21 years of age	21.0%	23.0%
Two Preventive Dental Services, at least six months apart, ages 1–20 years	27.1%	30.1%
Two Preventive Dental Services, at least six months apart, ≥ 21 years of age	8.4%	10.4%

As shown in **Table 9a**, the baseline rates for the percentage of members who received at least one preventive dental service for the members aged 1–20 years and 21+ years 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+ years age group. The baseline rates for the percentage of members who received at least two preventive dental services for members aged 1–20 years and 21+ years 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+ years age group.

To improve the rate of members receiving preventive dental care, MCNA has identified several barriers. 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.

To overcome these barriers, MCNA has deployed a number of interventions in 2019. 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.

Interim results for CY 2019 for the performance indicators and all intervention tracking measures will be available in April 2020 and incorporated into next year's annual technical report.

Nebraska Quality Strategy

Nebraska's Quality Strategy (originally approved in July 2003) was last rewritten 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, including:

- 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, and 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; and
- 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/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 7,500 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;
- assisted uninsured people with locating free or reduced-cost dental care;
- donated dental kits and oral hygiene information to various shelters in Lincoln, Nebraska, and the surrounding areas;
- donated various supplies, including dental kits, to victims of the 2019 floods;
- assisted participants at the 2019 NE Mission of Mercy in Omaha; and
- contacted members who have not had a dental visit in 6 months or longer to offer assistance with scheduling a visit.

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, Nebraska Mission of Mercy, Oasis Visionary Youth spring and winter events, 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, Central Nebraska Community Action Program, People's City Mission, 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.

Assessment of MCNA's Follow-up on Prior Recommendations

MCNA's Response to RY 2019 (MY 2018) EQR Recommendations

Federal EQR regulations for external quality review results and detailed technical reports at §438.364 require that the EQR include in each annual report an assessment of the degree to which each MCE has addressed the recommendations for quality improvement made in the prior EQR technical report. **Table 10** provides an assessment of the degree to which MCNA effectively addressed the improvement recommendations made by IPRO during the previous reporting year.

Table 10: Assessment of MCNA's Response to Prior Year Recommendations

Domain	IPRO Recommendation for RY 2019	MCO Response to Prior Year Recommendations
Quality	Incorporate language pertaining to only one level of member appeal into MCNA's policies and procedures and in their member handbook and provider manual.	Policy 13.200, Policy 13.100, and Policy 13.203 were updated to reflect that members have only one level of appeal through MCNA. The member handbook was updated on page 31 to reflect the following: "MCNA has a one-level appeal process." The member handbook was approved by MLTC on 11/4/19. The provider manual was updated on page 63 to reflect the following: "A member has the right to file an appeal through MCNA's one-level appeal process." The provider manual was approved by MLTC on 1/7/20.
Quality	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.	Policy 13.100 Grievances and Appeals notes the following: "The individual addressing the appeal or grievance must be a health care professional with the appropriate 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."
Quality	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.	The member handbook was updated to reflect the following on page 22: "If you have an emergency relating to your physical or behavioral services, you need to contact your Heritage Health Plan. Non-dental emergencies are not covered by MCNA." The member handbook was approved by MLTC on 11/4/19.
Quality	Add language to the member handbook pertaining to copayments.	The member handbook was updated on page 13 to read as follows: "There are no member copayments." The member handbook was approved by MLTC on 11/4/19.
Quality	Add an easily accessible feature to MCNA's website to accommodate the visually impaired who have difficulty reading. The DBPM should consider incorporating a bi-directional communication capability for members to obtain real-time answers to questions.	An interactive contact form was added to the MCNANE.net website that allows any website visitor to submit a secure message to MCNA's Nebraska Member Services Representatives and receive a response via email and/or phone. This dedicated Nebraska inbox has been confirmed to

Domain	IPRO Recommendation for RY 2019	MCO Response to Prior Year Recommendations
		be used by members since it was implemented. The contact form may be found here: https://www.mcnane.net/#contact. A prominent font-size selector was added to the header of the MCNANE.net website to accommodate visitors with visual impairments or requiring larger font sizes, as was recommended by IPRO during the last audit.
Quality	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.	The member handbook was updated on page 35 to reflect this information within the section titled "MCNA Programs and Policies." The member handbook was approved by MLTC on 11/4/19.
Timeliness	Remove the language related to a state fair hearing from the grievance acknowledgement letter because state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days).	The language regarding the state fair hearing was removed from the grievance acknowledgement letter.
Timeliness	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).	The language regarding the state fair hearing was removed from the grievance acknowledgement letter.
Timeliness	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).	Policy 3.203NE was updated on page 3 to reflect the following language: "The pre-authorizations must be finalized within 25 calendar days of receipt of the request, regardless of the type of service authorization."
Timeliness	Include information about informal reconsideration in the notice of action to the member.	The MCNA Notice of Adverse Benefit Determination (NABD) was updated to include information regarding informal reconsideration. The NABD was approved by MLTC on 10/18/18.

IPRO: Island Peer Review Organization; RY: reporting year; MCO: Managed care organization; MCNA: Managed Care of North America; MTLC: Medicaid and Long-Term Care; DBPM: dental benefits program manager; NABD: Notice of Adverse Benefit Determination.

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-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-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-year cycle;
- regulations for which the MCE received less than full compliance on the prior review by either the EQRO or accrediting organization;
- 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 the EQRO and/or state;
- Quality Management: Measurement and Improvement – Quality Assessment and Performance Improvement ([QAPI] 42 CFR 438.240) is assessed annually, as required by federal regulations.

The annual compliance review for April 2018–March 2019, conducted in May 2019, addressed contract requirements and regulations in the following categories:

- Provider Network,
- Provider Services,
- Member Services and Education,
- Quality Management,
- Utilization Management,
- Subcontracting, and
- 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** 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., sub-standards). 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;
- 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
Partial compliance	MCE has met some requirements of the standard, but is deficient in some areas that must be remediated
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.

Additionally, IPRO began its "desk review," or offsite review, when the pre-onsite documentation and case files were 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. 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 2019 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.

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 in this report. Analysis includes review of the study topic, questions, indicators, target population, data collection procedures, and interventions. Sampling was not applicable in 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.

Appendix C: Validation of Performance Measures

Objectives

Medicaid MCEs calculate performance measures to monitor and improve processes of care. As per the CMS regulations, validation of performance measures is one of the mandatory EQR activities.

The primary objectives of the performance measure validation process are to assess the:

- MCE's process for calculating performance measures and to determine whether the process adhered to the specifications outlined for each measure; and
- accuracy of the performance measure rates, as calculated and reported by the MCE.

Technical Methods of Data Collection

The methodology for validation of performance measures is based on the CMS protocol, "Validating Performance Measures." The activities defined in the protocol include assessment of:

- the structure and integrity of the MCE's underlying information system (IS);
- MCE's ability to collect valid data from various internal and external sources;
- vendor (or subcontractor) data and processes, and the relationship of these data sources to those of the MCE;
- MCE's ability to integrate different types of information from varied data sources (e.g., member enrollment data, claims data, pharmacy data, vendor data) into a data repository or set of consolidated files for use in calculating PMs; and
- documentation of the MCE's processes to collect appropriate and accurate data, manipulate the data through programmed queries, internally validate results of the operations performed on the data sets, follow specified procedures for calculating the specified PMs, and report the measures appropriately.

While the protocol provides methods of evaluation, tools and worksheets, and activities to be performed, it also specifies that other mechanisms and methods of assessment may be used, as long as they are consistent with the protocol objectives and outcomes. IPRO utilized this protocol to validate MCNA's performance measures.

Description of Data Obtained

In October 2019, IPRO requested and received from MCNA the following documentation related to performance measure calculation:

- specific procedures used to determine the measure numerators and denominators;
- a rate sheet of measures including measure name, description, denominator, numerator and rate;
- source code for each measure, as well as data and field definitions;
- member-level detail files via an Excel spreadsheet, with separate worksheets for each of the measures being reported. Member-level detail files included all applicable members in the denominator and the following fields for each worksheet:
  - member ID;
  - last name;
  - first name;
  - date of birth (DOB);
  - gender;
  - age;
  - numerator compliant (Y/N);
  - date(s) of service (for compliant members);
  - enrollment data; and
  - any additional fields, as appropriate, such as provider, diagnosis or procedure codes.

Data Aggregation and Analysis

IPRO reviewed the source code script provided by MCNA for reasonability and to ensure that the measure specifications were adhered to for measure calculation. IPRO then conducted numerator and denominator validation by analyzing the member-level data files provided for each measure and ensuring the data elements, such as enrollment dates, dates of

service, and dates of birth for each member, complied with denominator specifications. The eligible population numerator compliant records in the files were reviewed to ensure accurate calculation by MCNA.

Subsequent to the validation process, a report of the findings and recommendations was prepared and distributed to MLTC and MCNA.

IPRO will conduct an information systems capabilities assessment (ISCA) to assess the integrity of the MCE's information system and the completeness and accuracy of the performance measure data as part of the annual compliance review in May 2020.