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 2019–2020
April 2021

IPRO
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realized.

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Table of Contents

List of Tables

Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) 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 Medicare and Medicaid 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 of, timeliness of, 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 EQRO, 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—Three performance improvement projects (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—IPRO reviewed performance measures (PMs) 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 2020, specific findings, strengths and recommendations are described in detail in the **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** section of 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) 2019, MCNA continued a PIP to increase the percentage of members receiving annual dental visits. The PIP employed the modified Healthcare Effectiveness Data and Information Set (HEDIS®) Annual Dental Visit (ADV) measure, stratified into three age groups: 1–20 years, 2–20 years, and 21+ years. The interim period for the PIP was 1/1/2019 through 12/31/2019. Analysis of MCNA's baseline data showed the ADV rate for ages 1–20 years was 64.9%, for ages 2–20 years was 68.2%, and for ages 21+ years was 42.6%. The interim rates for ages 1–20 years, 2–20 years, and 21+ years were 65.4%, 68.4% and 41.9%, respectively. Lastly, the final goal for ages 1–20 years, 2–20 years, and 21+ years were 67.9%, 69.7% and 44.1%, respectively.

MCNA also continued a PIP to address members receiving preventive dental care at least twice per year. The PIP employed 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 rates for the percentage of members who received at least one preventive dental service for members aged 1–20 years and 21+ years were 54.6% and 21.01%, respectively. The interim rates for CY 2019 for members aged 1–20 years and 21+ years were 55.3% and 20.7%, respectively. MCNA's goal is to increase this rate to 58.6% for the 1–20 years age group and to 23.0% for the 21+ year age group by the end of the PIP in 2020. 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. The interim rates were 28.5% for ages 1–20 years and 9.2% for ages 21+ years. 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 by the end of the PIP in 2020.

Final measurement year (MY) results for CY 2020 for the performance indicators and all intervention tracking measures will be available in April 2021, upon submission of the final report, and incorporated into next year's annual technical report.

Performance Measurement

As required by federal Medicaid external quality review (EQR) regulations and requirements, under contract with NE DHHS, as the EQRO, IPRO was tasked with validating the reliability and validity of MCNA'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 PM stewards.

IPRO conducted validation of MCNA's reported PMs in November 2020 for HEDIS MY 2019. This included review of member-level detail files of the eligible population for each applicable measure, review of MCNA's information system capabilities, 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 PMs.

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

- work with MLTC to outreach NCQA to discuss the calculation of the HEDIS ADV measure for future reporting; and
- continue to work with MLTC staff to resolve any issues that might have an impact on the accurate and complete reporting of encounter data. It should be noted that following this recommendation to outreach NCQA, MCNA indicated that they will be using certified software moving forward.

Compliance Review

MCNA received a designation of full compliance for Provider Services, Subcontracting, Utilization Management, Grievances and Appeals, and Member Services and Education. The DBPM received a designation of partial compliance for Quality Management. MCNA received a designation of non-compliance for three elements under Quality Management:

- Of the 21 standards reviewed for Quality Management, 13 standards were fully compliant, 3 were partially compliant, and 3 were non-compliant. Two (2) standards were not applicable. The following details findings from the review of the partially compliant and non-compliant standards for the domain of Quality:
  - During the previous annual compliance review (May 2019), it was observed that a CAHPS survey was not utilized to assess member satisfaction. The DBPM indicated that a pediatric dental survey for CAHPS is currently unavailable. The only survey related to dental care 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. Thus, the DBPM does not believe it is an appropriate tool to use in their member population.
  - Survey results were reported to MLTC. The survey was based on inbound calls to the Member Call Center. Outbound calls were used to supplement, as necessary, and to ensure results could be compiled from a statistically significant portion of the population. MCNA did not detail the number of surveys that were attributed to inbound calls versus outbound calls. A total of 689 surveys were completed. This total represents a very small percentage (~0.2%) of MCNA's population of 241,693 (as of 12/2019). The DBPM should consider evaluating parent/guardian satisfaction with their child's dental care and analyzing those results alongside adult satisfaction scores to see if there is a significant difference.
  - The DBPM assessed provider satisfaction with provider relations, pre-authorization process, appeals, claims, provider services, and overall provider experience with MCNA. Provider enrollment and provider complaints were not evident in the report. On the day of the review, MCNA indicated that provider enrollment is handled by the state agency, and thus MCNA does not include a question regarding the provider enrollment process in its provider survey. MCNA received 10 provider complaints during CY 2018. Given the CY 2018 complaint volume compared to MCNA's network size, MCNA did not add a provider complaint question to the 2019 provider survey, given the question would not be valid to the vast majority of MCNA's provider network. MCNA received one complaint in CY 2019.

- Non-compliant standard(s)
  - 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.
  - MCNA did not follow CAHPS or CAHPS-like methodology; thus, the validity and reliability of survey results should be interpreted with caution. While statewide results were provided, results by county were not; however, regions were stratified and presented in the survey report: central, eastern, northern, southeast, and western.
  - Statistical analysis for targeting improvement efforts was not demonstrated. Comparisons to national/state benchmarks are not applicable, as this is not a standardized survey.

In the domain of Quality, IPRO recommends that MCNA:

- partner with University of Alabama at Birmingham to address the prior findings related to inconsistent CAHPS methodology;
- ensure child and adult findings are reported separately to MLTC;
- ensure that results are stratified by county;
- ensure a statistically random sample is drawn, based on members who have had a dental visit with an MCNA provider, in order to be consistent with CAHPS methodology;

- 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. In an effort to compare performance of MCNA in Nebraska, the DBPM might consider comparing against other states in which they operate with a similar benefit structure; and
- include questions in their provider satisfaction survey that assess perceptions of the enrollment process and complaint resolution process. The DBPM explained that the state handles provider enrollment; however, perceptions of this process should still be taken into consideration at the state's request. Further, only one complaint received during the review period indicates that there may be a discrepancy in what qualifies as a provider complaint and what is formally recorded as such. The DBPM should include a question in the Provider Survey to assess the complaint process, with "N/A" as a choice for those providers that did not file a complaint (formally or informally) with the DBPM during the year.

Timeliness

The Timeliness domain includes findings from two of the seven compliance domains: Utilization Management, and Grievances and Appeals.

Compliance Review

There were no partially compliant or non-compliant standards related to timeliness for Utilization Management, and for Grievances and Appeals. MCNA received a designation of full compliance for Utilization Management, and for Grievances and Appeals.

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

Access

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

Compliance Review

There were no partially compliant or non-compliant standards related to access for Provider Network. 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 NE DHHS, MLTC. 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 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 (**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 PH 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.

In October 2020, MLTC received federal approval for the Heritage Health Adult (HHA) Expansion Program as part of Nebraska's Medicaid Expansion initiative, which seeks to improve health outcomes and encourage life successes for Medicaid beneficiaries. Under the HHA program, Medicaid coverage is available to adults ages 19–64 years with incomes up to 138% of the federal poverty level. The HHA Expansion Program covers two benefits packages: basic benefits, including PH, BH, and prescription drug coverage, and prime benefits, including all basic benefits plus dental, vision, and over-the-counter (OTC) drug coverage. Those eligible for prime benefits include members ages 19–20 years, pregnant members, and the medically frail. As of November 1, 2020, there were 16,187 Nebraskans eligible for coverage under the HHA Expansion Program.

Table 1: Nebraska MCEs and Counties

MCEs	Counties
• Nebraska Total Care • UnitedHealthcare Community Plan of Nebraska • Healthy Blue (formerly 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 NE DHHS to provide services as a DBPM to Medicaid recipients residing in the counties noted in **Table 1**. For the month of December 2020, MCNA's membership totaled 302,724.

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 (SSA) 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 years 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 SSA;
- 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;
- members eligible during a period of presumptive eligibility; and
- members covered in the HHA Expansion Program, including adults ages 19–64 years with incomes up to 138% of the federal poverty level.

NE DHHS currently contracts with vendors to perform the following services for Heritage Health:

- PH managed care services,
- BH managed care services,
- enrollment broker services,
- EQR 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 Nebraska'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 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 2020, IPRO conducted a compliance monitoring virtual visit, validation of PMs, and validation of PIPs for MCNA. Each activity was conducted in accordance with CMS protocols for determining compliance with MMC 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 MCNA Insurance Company and Managed Care of North America, Inc. MCNA offers coverage in all 93 counties. **Table 2 presents** a summary of MCNA's 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 12/2020)	302,724
URAC (expiration date 3/1/2021)	Fully accredited[1]

[1] MCNA's accreditation status was extended until March 1, 2021, due to the 2019 Novel Coronavirus (COVID-19) pandemic.
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 HEDIS MY 2019 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, 2019–March 31, 2020. The review is based on information derived from IPRO's conduct of the annual regulatory compliance review, which took place in August 2020. 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 in **Table 3**. For each compliance domain, a description is provided, including: content reviewed, overall compliance designation, current year findings and recommendations (measurement period 4/1/2019–3/31/2020), and MCNA's response and action plan.

Table 3: Summary of Compliance Review Findings

Compliance Domain	Compliance 2019 (Measurement Period 9/1/18–3/31/19)									Compliance 2020 (Measurement Period 4/1/19–3/31/20)								
	n	Full		Partial		Non-compliant		Not Applicable		n	Full		Partial		Non-compliant		Not Applicable	
Grievances and Appeals	7	6	86%	1	14%	0	0%	0	0%	2	2	100%	0	0%	0	0%	0	0%
Member Services and Education	7	5	71%	2	29%	0	0%	0	0%	5	5	100%	0	0%	0	0%	0	0%
Provider Network	18	18	100%	0	0%	0	0%	0	0%	11	11	100%	0	0%	0	0%	0	0%
Provider Services	13	13	100%	0	0%	0	0%	0	0%	4	4	100%	0	0%	0	0%	0	0%
Quality Management	21	13	62%	2	10%	5	24%	1	5%	21	13	62%	3	14%	3	14%	2	10%
Subcontracting	2	1	50%	0	0%	0	0%	1	50%	2	2	100%	0	0%	0	0%	0	0%
Utilization Management	16	16	100%	0	0%	0	0%	0	0%	11	11	100%	0	0%	0	0%	0	0%

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 2 standards were reviewed; all 2 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, 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 5 standards were reviewed; all 5 were fully compliant.

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 11 standards were reviewed; all 11 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 4 standards were reviewed; all 4 were fully compliant.

Quality Management

The evaluation of quality management includes, but is not limited to, review of: QI Program Description; Annual QI Evaluation; QI Work Plan; QI Committee structure and function, including meeting minutes; PIPs; documentation related to PM 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, 3 were partially compliant, 3 were non-compliant, and 2 were deemed not applicable. Partially compliant quality management standards are presented in **Table 4**. Non-compliant quality management standards are presented in **Table 5**.

Table 4: Quality Management—Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
Annual Member Satisfaction Survey The DBPM must conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to	During the last annual compliance audit (May 2019), it was observed that a CAHPS survey was not utilized to assess member satisfaction. The DBPM indicated that a pediatric dental survey for CAHPS is currently unavailable. The only survey related to dental care is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit	MCNA has contracted with DataStat to administer the CAHPS member satisfaction survey and methodology.

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
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.	where members are capped at an annual amount of $750. Thus, the DBPM does not believe it is an appropriate tool to use in their member population. Given that the MLTC contract with MCNA specifies CAHPS, this requirement is only "partially addressed." MCNA did administer a survey in 2019, which had questions that mirror CAHPS. The survey response scale was skewed in a positive/favorable direction last year; is the scale still calculated the same this year? 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, as 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 the fact that the lowest possible score is 60, as opposed to 0). During the virtual onsite, MCNA indicated that they have partnered with University of Alabama Birmingham to administer their member satisfaction survey. This will more closely mirror the CAHPS methodology. **Recommendation** MCNA's partnership with University of Alabama Birmingham should help to address the prior findings related to inconsistent CAHPS methodology.	
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. The survey was based on inbound calls to the Member Call Center. Outbound calls were used to supplement, as necessary, to ensure results could be compiled from a statistically significant portion of the population. MCNA did not detail the number of surveys that were attributed to inbound calls versus outbound calls. A total of 689 surveys were completed. This represents a very small percentage (~0.2%) of MCNA's population of 241,693 (as of 12/2019). The DBPM should consider evaluating parent/guardian satisfaction	MCNA has contracted with DataStat to administer the CAHPS member satisfaction survey and methodology wherein child and adult findings will be reported separately to MLTC.

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	with their child's dental care and analyzing those results alongside adult satisfaction scores to see if there is a significant difference. **Recommendation** MCNA's partnership with University of Alabama Birmingham should help to address the prior findings related to inconsistent CAHPS methodology. MCNA should ensure child and adult findings are reported separately to MLTC.	
Provider Satisfaction Surveys The DBPM must conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction Survey tool and methodology must be submitted to MLTC for approval prior to administration.	This requirement is partially evidenced in MCNA's 2019 MCNA Nebraska Provider Satisfaction Survey Results and Analysis Report. The DBPM assessed provider satisfaction with provider relations, pre-authorization process, appeals, claims, provider services, and overall provider experience with MCNA. Provider enrollment and provider complaints were not evident in the report. On the day of the review, MCNA indicated that provider enrollment is handled by the state agency, and thus MCNA does not include a question regarding the provider enrollment process in its provider survey. MCNA received 10 provider complaints during calendar year 2018. Given the calendar year 2018 complaint volume compared to MCNA's network size, MCNA did not add a provider complaint question to the 2019 provider survey, given the question would not be valid to the vast majority of MCNA's provider network. MCNA received one complaint in calendar year 2019. **Recommendation** MCNA should include questions in their provider satisfaction survey that assess perceptions of the enrollment process and complaint resolution process. The DBPM explained that the state handles provider enrollment; however, perceptions of this process should still be taken into consideration at the state's request. Further, only one complaint received during the review period indicates that	MCNA will include questions in our 2020 Provider Satisfaction Survey that will address the provider enrollment and complaint resolution processes.

Partially Compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
	there may be a discrepancy In what qualifies as a provider complaint and what is formally recorded as such. The DBPM should include a question in the Provider Survey to assess the complaint process, with "N/A" as a choice for those providers that did not file a complaint (formally or informally) with the DBPM during the year.	

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

Table 5: Quality Management—Non-compliant Standards

Non-compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
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. MCNA's partnership with University of Alabama Birmingham should help to address the prior findings related to inconsistent CAHPS methodology.	MCNA has contracted with DataStat to administer the CAHPS member satisfaction survey and methodology wherein a statistically random sample will be selected for both children and adults who have had a dental visit with an MCNA provider.
The surveys must provide valid and reliable data for results statewide and by county.	MCNA did not follow CAHPS or CAHPS-like methodology; thus, the validity and reliability of survey results should be interpreted with caution. While statewide results were provided, results by county were not (however, regions were stratified and presented in the survey report: central, eastern, northern, southeast, and western). **Recommendation** MCNA's partnership with University of Alabama at Birmingham should help to address the prior findings related to inconsistent CAHPS methodology. MCNA should ensure that results are stratified by county.	MCNA has contracted with DataStat to administer the CAHPS member satisfaction survey and methodology wherein results will be stratified by county.
Analysis must provide statistical analysis for targeting improvement	Statistical analysis for targeting improvement efforts was not demonstrated. Comparisons to	MCNA has contracted with DataStat to administer the CAHPS member satisfaction survey and methodology.

Non-compliant Standards	Findings and Recommendations for Improvement	MCNA Response and Action Plan
efforts and comparison to national and state benchmark standards.	national/state benchmarks are not applicable, as this is not a standardized survey. **Recommendation** MCNA's partnership with University of Alabama Birmingham should help to address the prior findings related to inconsistent CAHPS methodology. MCNA 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. In an effort to compare performance of MCNA in Nebraska, the DBPM might consider comparing against other states in which they operate with a similar benefit structure.	The analysis will include quantifiable analysis as performed by DataStat and included in their final report. This analysis will include stratified results based on age, sex, and cultural demographics. MCNA's QI staff will perform qualitative analysis through the QI structure, which includes multi-disciplinary review and input from the Quality Improvement Committee (QIC). The QIC will ensure the final analysis is thorough and includes recommended plan-wide activities to improve member satisfaction results. MCNA will compare performance against other states as applicable.

MCNA: Managed Care of North America; DBPM: dental benefits program manager; CAHPS: Consumer Assessment of Health care Providers and Subsystems; QI: Quality Improvement.

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 were reviewed; all 2 were fully compliant.

Utilization Management

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

A total of 11 standards were reviewed; all 11 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 NE MLTC under the DHHS. Federal MMC regulations 438.330 (C)(1) and (C)(2), Performance Measurement, require that the Medicaid MCOs, PAHPs, and 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 MCEs' performance. As a result, a requirement of the Nebraska Medicaid PAHP contract is the annual reporting of PMs. These PMs, selected by MLTC, include the HEDIS, Dental Quality Alliance (DQA), 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 HEDIS MY 2019 and under contract to NE DHHS, MCNA, Nebraska's 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 PMs, which must be submitted to MLTC at least quarterly (administrative PMs) or annually (clinical PMs).

As required by federal Medicaid EQR regulations and requirements, under contract with NE DHHS, as the EQRO, 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 PM stewards.

IPRO conducted validation of MCNA's reported PMs in November 2020 for HEDIS MY 2019. This included review of member-level detail files of the eligible population for each applicable measure, an Information Systems Capability Assessment (ISCA), 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 PMs.

IPRO issued the following determinations of compliance for HEDIS MY 2019:

Enrollment Systems: Compliant

- MCNA is able to track membership and membership changes and assign a unique member ID for each member. The eligibility system captures enrollment breaks and data elements necessary to stratify reporting based on subpopulations. The system is able to link a member when there is a change in a member ID number on the 834 daily eligibility file and retain historical eligibility information for a period of 10 years.

Claims/Encounter Systems: Compliant

- MCNA's claim processing system, DentalTrac, is robust and configured to address government healthcare functions. The system captures CDT codes and all of the necessary information to report PMs and transmit encounter data to MLTC accurately, completely, and on a timely basis. MCNA's quality control and audit procedures are well-documented and compliant and procedural and financial claims accuracy is reported to be above 95% for HEDIS MY 2019.
- MCNA maintains data integrity at all times and information is never changed or altered.
- Historical claims information is retained for a period of 10 years.

Reporting: Compliant

- MCNA has a robust reporting repository for both PM reporting and transmission of encounter data to MLTC.
- There is one open issue that was discussed during the virtual interview regarding PM reporting that will impact MCNA's capability to report the HEDIS ADV measure in CY 2021. The National Committee for Quality Assurance (NCQA) has recently issued guidance that any public reporting of HEDIS measures requires that they be calculated using an NCQA-certified source code vendor. MCNA has in the past calculated the HEDIS ADV measure using internal

source code (code that is not NCQA certified), but which has been validated by IPRO, as MLTC's EQRO. This process seemingly is no longer compliant with NCQA policies for measures that are publicly reported.

It was recommended that MLTC and/or MCNA outreach to NCQA to discuss the calculation of this measure for future reporting. IPRO staff is available to be part of the discussion with NCQA. Alternatively, the state can waive reporting of this measure because MCNA is reporting measures similar in content to the HEDIS ADV measure. All other PMs reported by MCNA, including one Child Core measure and three DQA measures, are not relevant to this discussion. Following this recommendation, MCNA indicated that they will be using certified software moving forward.

Encounter Data Submissions: Compliant

- MCNA's systems have the capability of tracking and reconciling the encounter data submitted to MLTC.
- MCNA ensures the accuracy and completeness of encounter data are incorporated into their reporting repository and submitted to MLTC timely and accurately.
- During the virtual interview, it was apparent that MCNA's staff is knowledgeable and understands the Nebraska encounter data submission processes and business needs. MCNA's analysis of denied encounters is a continuous process, they communicate well, and they appear to maintain a good relationship with MLTC.

Based upon IPRO's review of MCNA's ISCA responses and their discussion of their system capabilities during the virtual interview, with the exception of the one open item regarding reporting of the HEDIS ADV measure, there are no components of the ISCA process that require corrective action or are considered opportunities for improvement. MCNA is encouraged to continue to work with MLTC staff to resolve any issues that might have an impact on the accurate and complete reporting of encounter data.

The PM validation for reporting year 2021 (HEDIS MY 2020) will be conducted in Q4 2021.

Table 6 presents the measures validated descriptions of each measure and the calculated rates for each measure.

Table 6: Nebraska Medicaid HEDIS MY 2019 Performance Measures MCNA—RY 2020

Nebraska Medicaid 2020 Performance Measures MCNA—RY 2020					
Measure Name	**Admin (A)/ Hybrid (H)**	**Measure Definition**	**RY 2020 Member Denominator**	**RY 2020 Member Numerator**	**RY 2020 Rate**
Child Core Measure					
Preventive Dental Services (Pdent)	A	The percentage of members 1–20 years of age who received at least one preventive dental service by or under the supervision of a dentist during the measurement year.	178,946	99,615	55.67%
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.	16,175	8,755	54.13%
		The percentage of members 4–6 years of age who had at least one dental visit during the measurement year.	24,424	17,951	73.50%
		The percentage of members 7–10 years of age who had at least one dental visit during the measurement year.	31,323	24,174	77.18%
		The percentage of members 11–14 years of age who had at least one dental visit during the measurement year.	30,431	21,464	70.53%
		The percentage of members 15–18 years of age who had at least one dental visit during the measurement year.	23,087	14,156	61.32%
		The percentage of members 19–20 years of age who had at least one dental visit during the measurement year.	2,205	973	44.13%
		Total ADV (2–20 years of age).	127,645	87,473	68.53%
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.	169,390	100,623	59.40%
TRT-CH-A	A	The percentage of enrolled children under 21 years of age who received a treatment service within the reporting year.	169,390	35,347	20.87%
OEV-CH-A	A	The percentage of enrolled children under 21 years of age who received a comprehensive oral evaluation within the reporting year.	169,390	94,619	55.86%
CCN-CH-A	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.	138,876	64,305	46.30%

MCNA: Managed Care of North America; RY: reporting year.

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 are 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 interim reports were submitted in April 2020. Brief summaries of these PIPs are presented below.

PIP: Annual Dental Visit

In CY 2020, MCNA continued their PIP to increase the percentage of members receiving annual dental visits. The PIP employed the modified HEDIS ADV measure, stratified into three age groups: 2–20 years, 1–20 years, and 21+ years. The ADV measure evaluated 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, and the interim period for the PIP was 1/1/19–12/31/19 (**Table 7**).

Table 7: Members With Annual Dental Visit PIP

Indicator	Baseline Rate	Interim Rates	Target Goal
Annual Dental Visit—ages 1–20 years	64.9%	65.4%	67.9%
Annual Dental Visit—ages 2–20 years	68.2%	68.4%	69.7%
Annual Dental Visit—ages 21+ years	42.6%	41.9%	44.1%

PIP: performance improvement project.

As shown in **Table 7**, the baseline rate for the ADV measure for ages 2–20 years was 68.2%, the rate for ages 1–20 years was 64.9%, and the rate for ages 21+ years was 42.6%. The interim rates were 65.4%, 68.4%, and 41.9% for ages 1–20 years, 2–20 years, and 21+ years, respectively. The final goal for ages 2–20 years, 1–20 years, and 21+ years were 69.7%, 67.9%, and 44.1%, respectively.

To reach and surpass each target goal, MCNA identified barriers and designed several interventions to apply as part of the PIP. Member-specific barriers cited by MCNA included 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, a text message to parents of members' turning 1 year old, and member advocate outreach specialist participation in community outreach events/health fairs. These interventions began on 1/1/19 and continued through the end of the PIP in December 2020, or were postponed as described below.

A provider-specific barrier identified by MCNA was that PCPs were unaware of MCNA's participating provider network in the proximity of their offices. To address this barrier, MCNA implemented the Dental Link Program, 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 continued through the end of the PIP in December 2020.

Many of MCNA's planned interventions for 2019 were not carried out as planned due to lack of Heritage Health plan participation. These include the Baby's First Toothbrush Program and the DentalLink Program. Both were rescheduled but then postponed due to the COVID-19 pandemic. Regarding MCNA's text message program, there were system-/IT-related challenges, which pushed this intervention to be implemented in March 2020. On average, the percentage of members who were educated about their gaps in care increased from Q1 2019 to Q3 2019 and decreased in Q4 2019. The same trend was observed for members who were assisted with appointment scheduling.

Final results for CY 2020 for the ADV measure and all intervention tracking measures will be available in April 2021, upon final report submission, and incorporated into next year's annual technical report.

PIP: Preventive Dental Visit (Pdent)

In CY 2020, MCNA continued their PIP to increase the percentage of members receiving preventive dental visits for members aged 1–20 years and members aged 21+ years. The PIP employed 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, and the interim period for the PIP was 1/1/19–12/31/19 (**Table 8**).

Table 8: Preventive Dental Services PIP

Indicator	Baseline Rate	Interim Rate	Target Goal
One Preventive Dental Service, ages 1–20 years	54.6%	55.3%	58.6%
One Preventive Dental Service, ages 21+ years	21.0%	20.7%	23.0%
Two Preventive Dental Services, at least 6 months apart, ages 1–20 years	27.1%	28.5%	30.1%
Two Preventive Dental Services, at least 6 months apart, ages 21+ years	8.4%	9.2%	10.4%

PIP: performance improvement project.

As shown in **Table 8**, 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. The interim rates were 55.2% for ages 1–20 years, demonstrating an increase from baseline, and 20.7% for ages 21+ years, demonstrating a slight decrease from baseline. 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. The interim rates were 28.5% for ages 1–20 years and 9.2% for ages 21+ years, demonstrating an increase from baseline in both age groups for preventive dental services.

To further improve the rate of members receiving preventive dental care, MCNA identified several barriers. Member-specific barriers cited by MCNA included 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 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 faced 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 had no access to medical, diagnostic data for its members.

To overcome these barriers, MCNA deployed a number of interventions in CY 2019. Member-specific interventions cited by MCNA included text messages to members who had 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, a text message to parents of members turning 1 year old, community outreach, 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 provided training on its DentalLink Program for high-volume, medical, participating 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.

Many of MCNA's planned interventions for 2019 were not carried out as planned due to lack of Heritage Health plan participation. These include the Baby's First Toothbrush Program and the DentalLink Program. Both were rescheduled but then postponed due to the COVID-19 pandemic. Regarding MCNA's text message program, there were system-/IT-related challenges, which pushed this intervention to be implemented in March 2020. On average, the percentage of

members who were educated about their gaps in care increased from Q1 2019 to Q3 2019 and decreased in Q4 2019. The same trend was observed for members who were assisted with appointment scheduling.

Final results for CY 2020 for the performance indicators and all intervention tracking measures will be available in April 2021, upon submission of the final report, and incorporated into next year's annual technical report.

Nebraska Quality Strategy

Nebraska's Quality Strategy (originally approved in July 2003) was rewritten in 2017 in response to Nebraska's 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. The strategy was updated in 2020 to address the approval of the Medicaid Expansion program via Initiative 427, which was launched in October 2020 as the Heritage Health Adult Program. As part of its Quality Strategy, NE DHHS requires that all MCEs have methods to determine the quality and appropriateness of care for all Medicaid enrollees under the Nebraska MMC contracts.

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

- MLTC and CMS may inspect and audit any records of the DBPM or its subcontractors. There is no restriction on the right of MLTC or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.
- The DBPM's Quality Assessment and Performance Improvement (QAPI) Program objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. The results of these activities are reported to MLTC annually.
- The DBPM conducts annual member satisfaction surveys to assess the quality and appropriateness of care to members each contract year.
- The DBPM's policies and procedures include the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, and efficiency of dental care services. Policies and procedures provide guidance for assessing the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

The full version of Nebraska's Quality Strategy can be found on the NE DHHS website (http://dhhs.ne.gov/Documents/NE%20Quality%20Strategy.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, Healthy Blue, 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 2020 (HEDIS MY 2019) 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. An assessment of the degree to which MCNA effectively addressed the improvement recommendations made by IPRO during the previous reporting year is included in **Table 9**.

Table 9: Assessment of MCNA's Response to Prior Year Recommendations

Domain	IPRO Recommendation for RY 2020	DBPM Response to Prior Year Recommendations
Quality	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 has not implemented bi-directional chat but has implemented secure messaging via a dedicated Nebraska inbox.
Quality	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.	This has been added to our member handbook.
Quality	Ensure that all care management activities are summarized and evaluated in the DBPM's QI Program evaluation.	This change has been integrated and was evidenced in the 2019 QI Program Evaluation. This was notated as fully compliant by IPRO in their March 2020 report.
Quality	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.	The most recent review conducted by IPRO finalized March 2020, indicates MCNA received full compliance for provider satisfaction surveys. No additional changes are planned at this time.
Quality	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.	MCNA has contracted with DataStat, a certified CAHPS survey vendor, to conduct a survey of 2020 member satisfaction. This will be completed during the first two quarters of 2021.
Quality	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.	MCNA has contracted with DataStat, a certified CAHPS survey vendor, to conduct a survey of 2020 member satisfaction. This will be completed during the first two quarters of 2021.
Quality	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.	MCNA has contracted with DataStat, a certified CAHPS survey vendor, to conduct a survey of 2020 member satisfaction. This will be completed during the first two quarters of 2021.
Quality	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.	MCNA has contracted with DataStat, a certified CAHPS survey vendor, to conduct a survey of 2020 member satisfaction. This will be completed during the first two quarters of 2021.

Domain	IPRO Recommendation for RY 2020	DBPM Response to Prior Year Recommendations
Quality	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.	MCNA has contracted with DataStat, a certified CAHPS survey vendor, to conduct a survey of 2020 member satisfaction. This will be completed during the first two quarters of 2021.
Timeliness	Review appeals policies and procedures for timeliness with staff to ensure that all standard appeals received are acknowledged within 10 calendar days of receipt.	MCNA has completed staff training for timeliness of appeals.

RY: reporting year; MCNA: Managed Care of North America; DBPM: dental benefits program manager; MTLC: Division of Medicaid and Long-Term Care; QI: Quality Improvement; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

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 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 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 3-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 2019–March 2020, conducted in August 2020, 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 the **Description of Data Obtained** and **Compliance Monitoring** sections of 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 such as reports and case files were requested to be available for the onsite visit.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing was requested of grievances received by the MCE for a selected time period; or, for care coordination, a listing was requested 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.

Virtual Onsite Activities—A virtual onsite review was conducted in response to the COVID-19 pandemic in 2020, which prevented travel and in-person activities. The virtual onsite review commenced with an opening conference, during which 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 reviewed open items and conducted a preliminary review of the results for each section. Staff interviews were conducted to clarify and confirm findings. When appropriate, walk-throughs or demonstrations of work processes were conducted virtually. The virtual 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 in the

Virtual Onsite Activities section, staff interviews and demonstrations were conducted during the virtual 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 2020 review is included in the **Compliance Monitoring** section of this report.

Data Aggregation and Analysis

Post-onsite Activities—Following the virtual 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 and offered 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 were 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 reports and in collaboration with NE DHHS's data and analytics team (to validate statewide averages and 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 are enumerated.
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk are enumerated.

Appendix C: Validation of Performance Measures

Objectives

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

The primary objectives of the PM validation process are to assess the:

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

Technical Methods of Data Collection

The methodology for validation of PMs 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 PMs.

Description of Data Obtained

In October 2020, IPRO requested and received from MCNA the following documentation related to PM 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 conducted an information systems capabilities assessment (ISCA) to assess the integrity of the MCE's information system and the completeness and accuracy of the HEDIS 2019 PM data as part of the annual compliance review in August 2020.