Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

July 1, 2022

Effective October 1, 2022 to September 30, 2027

NE03.R12 Renewal Approved by CMS on 07282020

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Programs

A. **Facesheet**
Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of **Nebraska** requests a**n amendment under the authority of Section 1915(b) of the Social Security Act.** The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **Heritage Health.** (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

☐ Initial request for new waiver. All sections are filled.

☐ Amendment request for existing waiver, which modifies Section/Part _A, B, D___

- ☐ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver). Sections A and B are revised to reflect this waiver renewal request.
- ☐ Document is replaced in full, with changes highlighted.

☒ Renewal request

- ☐ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
- ☒ The State has used this waiver format for its previous waiver period.

Section A is
☐ replaced in full
☒ carried over from previous waiver period. The State:
☐ assures there are no changes in the Program Description from the previous waiver period.
☒ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is
☐ replaced in full
☒ carried over from previous waiver period. The State:

☐ assures there are no changes in the Monitoring Plan from the previous waiver period.
☒ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Sections C and D are filled out.

Effective Dates: This amendment is requested to be implemented beginning October 1, 2022 and ending September 30, 2027.

(For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is: Matthew Ahern (402) 430-7631 or email at (matthew.ahern@nebraska.gov) and Todd Baustert (402 890-8939/ todd.baustert@nebraska.gov). Fax number: (402) 471-9092

Section A: Program Description

B. **Part I: Program Overview**

Tribal Consultation
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

See Attachment A: Tribal notice, submitted to Tribes on 05/27/2022. The tribal notice included the 1915(b) Waiver summary. The tribes were provided a thirty (30) day comment period. Following the thirty (30) day comment period no responses were received.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
In 1993, the Nebraska Legislature directed Medicaid and Long-Term Care (hereafter MLTC) to develop a Managed Care program. MLTC implemented the Nebraska Medicaid Managed Care Program in July 1995 through a Basic Benefits package. Effective January 1, 2017, MLTC branded the Managed Care program as Heritage Health, integrating Physical Health, Behavioral Health, and Pharmacy services. LTSS continues as FFS outside of managed care. Effective October 1, 2017, MLTC entered into a contract with Managed Care of North America (MCNA) to administer dental services to Heritage Health enrollees.

Enrollment into Heritage Health is mandatory and provides health care coverage for approximately 360,142 individuals each month at an annual cost of approximately $2.2 billion. The Enrollment Broker's (EB) responsibility is to provide impartial assistance to enrollees and automatically enrolling beneficiaries into a Managed Care Organization (MCO). The EB uses an algorithm to assign members to an MCO; the algorithm prioritizes familial relationships, prior member-provider relationships, and plan membership when assigning a member.

The current Managed Care program consists of the following components:

1. Heritage Health Managed Care Benefits
    a. Core Benefits Package provided by three Managed Care Organizations (MCOs), including mandatory physical health, behavioral health, non-emergency medical transportation, and pharmacy services;
2. Dental Benefits
    a. provided by one PAHP to Medicaid eligible individuals;
3. Enrollment Broker Services (EBS); and

4. Data Management Services.

The objectives of the Heritage Health Managed Care program continue to be the reduction of cost, prevention of unnecessary utilization, reduction of inappropriate utilization, and adequate access to quality services. Heritage Health consists of three current managed care organizations (MCOs): United Healthcare Community Plan (UHCCP), Nebraska Total Care (NTC), and HealthyBlue of Nebraska (HBN) (previously WellCare of Nebraska, Inc.). These Heritage Health contracts are effective January 1, 2017 through December 31, 2022 with the option to renew for two additional one-year extensions.

The implementation of Integrated Managed care was successful and had limited disruptions to member services and benefits delivery. The integration of physical and behavioral health to Nebraska has improved the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. The integration of BH services has added to the physical health delivery system, goals for all members include decreased reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment. The Heritage Health program simplified the delivery model for Medicaid recipients, by integrating physical health, behavioral health, and pharmacy benefits into single managed care contracts, heightening care and case management for beneficiaries. Since mental illness and SUDs may often co-occur along with chronic conditions such as heart disease, cancer, and diabetes, having one MCO responsible for the full range of services for a recipient encourages investment in more cost-effective services to better address the health care needs of the whole person.

Similar to the Heritage Health program, the dental managed care program has included important initiatives aimed at improving care coordination, as well as access to dental care for Medicaid eligible individuals. The dental benefits program manager (MCNA) contracted by MLTC encourages the utilization of preventative services, and promotes positive patient education.

November 2018 the residents of Nebraska voted in favor of initiative 427 to expand Medicaid eligibility to Nebraska residents 19-64 whose income is below the 138 percent poverty level. Nebraska has adopted legislative bill 294 to oversee the expansion. The Heritage Health MCOs and DBM administer the benefits package to the expansion population.

Effective October 1, 2020 the State of Nebraska includes expanded Medicaid coverage to include adults 19 to 64 years old, with income up to 138% FPL under a two-tier benefit category alternative benefit plan (ABP). Nebraska submitted a 1915(b) amendment on July 14, 2021 to discontinue the two benefit tier ABPs into a single category ABP for the expansion population. CMS approval was received on September 28, 2021. Effective October 1, 2021 all Medicaid eligible adults receive the same State Plan benefits as those previously eligible prior to expansion within a single category ABP.

On September 1, 2016, MLTC released a RFP to procure a dental plan to manage its dental benefits as a PAHP. The Dental Benefits Manager (DBM) will be responsible for developing a robust provider network and member outreach and education with the goal of increasing preventative utilization and reducing expensive, avoidable services.

On October 1, 2017, MCNA began providing dental coverage for all Medicaid eligible individuals.

Major MLTC Milestones in the Past Decade

Date	Description of Changes	New Populations	Major New Features and Programs
July 1, 1995	Implementation of a Managed Care program	Douglas, Sarpy, and Lancaster counties	Physical health and mental health/substance use Basic Benefits package (July 17, 1995)
March 1, 2013	Actuarial contract awarded.		Optumas begins their contract as Nebraska Medicaid's actuarial partner.
July 1, 2016	Amendment of 1915(b) waiver		Mandatory Subsidized Adoption and Basic Benefits package for Medicaid eligible children, and American Indians/Alaskan Natives for hospice and non-emergency transportation.
September 1, 2016	Enrollment Broker Services contract awarded.		Automated Health Systems awarded the contact as the Enrollment Broker Servicer.
January 1, 2017	Managed Care Integration	Medicaid and CHIP enrollees; coverage for all 93 counties in the state of Nebraska.	Physical Health, Behavioral Health, and Pharmacy services integrated into Heritage Health; LTSS remains FFS.
October 1, 2017	Dental Benefits Manager (DBM) contract begins for MCNA		MCNA begins providing dental coverage for all Medicaid eligible individuals.

March 1, 2018	Data warehouse contract assigned		Deloitte contracted to develop the new Data Management and Analytics system.
November 6, 2018	Passage of Initiative 427 to expand Medicaid		Nebraskans voted to expand Medicaid benefits to individuals 19 to 64 years old.
July 9, 2019	Approval received for Section 1115 SUD Demonstration	SUD services for individuals 21-64 years old.	CMS approval received for providing substance use disorder services within Institutions for Mental Diseases (IMDs). SUD services are authorized under 1915(b)(3).
October 1, 2020	Nebraska Medicaid Adult Expansion	Adults 19 to 64 years old.	State Plan benefits for adults 19 to 64 years old with income up to 138% FPL.
November 1, 2020	DHHS launches Health Interactive as new DMA		Implementation of a new Data Management and Analytics (DMA) system for processing encounter claims submitted by the managed care entities.
January 1, 2021	Managed Care Organization change		Wellcare of Nebraska, Inc. transitions to HealthyBlue of Nebraska as the 3rd MCO, following an MCO merger.
April 1, 2021	New External Quality Review contract begins.		Health Services Advisory Group Inc. (HSAG) awarded EQRO contract for providing annual audits of the MCEs. Compliance with 42 CFR Part 438, subpart E

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. ☒ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs **(MCO).**

b. ☒ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or **competing MCOs**/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ☒ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority. This applies to the MCOs and PAHP.

d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- ☒ MCO
- ☐ PIHP
- ☒ PAHP
- ☐ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- ☐ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ☐ **Section 1902(a)(1)** - State wideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program. This applies to the MCOs and PAHP.

c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an **MCO**, PIHP, **PAHP**, or PCCM**.**

d. ☒ **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or **PAHP**, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a. ☒ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
Heritage Health is currently the State of Nebraska's Managed Care program. MLTC contracts with three MCOs to provide coverage to members for Physical, Behavioral, and Pharmacy services.

b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that (1) provides medical services to enrollees under contract with the State agency on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates, (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees, and

(3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

☐ The PIHP is paid on a risk basis.
☐ The PIHP is paid on a non-risk basis.

c. ☒ **PAHP:** Prepaid Ambulatory Health Plan means an entity that (1) provides medical services to enrollees under contract with the State agency on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates, (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees, and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
The PAHP is the Dental Benefits Manager (DBM).

☒ The PAHP is paid on a risk basis.
☐ The PAHP is paid on a non-risk basis.

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.
☐ Reimbursement is the same as stipulated in the state plan
☐ Reimbursement is different than stipulated in the state plan (please describe)

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc.):

☒ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience**) for Actuarial Services, Data Management, EQRO, MCO, PAHP, and Enrollment Broker contracts.**

☐ **Open** cooperative procurement process (in which any qualifying contractor may participate)**.**

☐ **Sole source**:

☐ **Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an **MCO**, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities,**.**

☒ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or **PAHP** per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

MLTC operates the Dental Benefits Program under a single statewide PAHP. Enrollees have free choice of providers within the PAHP and may change providers as often as desired. The PAHP is required to contract with dental providers that are appropriately licensed and/or certified and meet the PAHP's credentialing criteria, who agree to the standard contract provisions, and who wish to participate. Within the PAHP's network, enrollees have a choice of providers that offer the appropriate level of care.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

☒ Two or more MCOs
☐ Two or more primary care providers within one PCCM system.
☐ A PCCM or one or more MCOs
☐ Two or more PIHPs.
☐ Two or more PAHPs.
☒ Other: (please describe): Two or more dental providers within one PAHP.

3. **Rural Exception.**

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

☒ **Statewide** -- all counties, zip codes, or regions of the State, this applies to the MCOs and PAHP.

☐ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (**MCO**, PIHP, **PAHP**, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide: Lancaster, Douglas and Sarpy, Cass, Dodge, Gage, Otoe, Saunders, Seward, Washington Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.	**MCO** **PAHP**	**MCO - United HealthCare of the Midlands, Inc. (Plan name: UnitedHealthcare Community Plan)** **MCO — Healthy Blue of Nebraska (Plan name: Healthy Blue of Nebraska** **MCO – Centene Incorporated Nebraska Total Care** **PAHP- Managed Care of North America. (Plan name: MCNA)**

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

☒ **PAHP**
☒ **MCO/**PCCM

☒ Mandatory enrollment
☐ Voluntary enrollment

Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

☒ **PAHP**
☒ **MCO/**

☒ Mandatory enrollment
☐ Voluntary enrollment

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

☒ **PAHP**
☒ **MCO/PCCM**
☒ Mandatory enrollment
☐ Voluntary enrollment

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment

☐ Voluntary enrollment

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment
☐ Voluntary enrollment

Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment
☐ Voluntary enrollment

TITLE XXI CHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment
☐ Voluntary enrollment

In addition to the mandatorily enrolled expansion CHIP population, MLTC Nebraska has a separate CHIP program, which is called 599 CHIP, for unborns of pregnant women otherwise ineligible for coverage under Medicaid or CHIP for the unborn. The 599 CHIP population is mandatorily enrolled in an MCO. But due to the limited benefits package for this group, coverage of dental services and enrollment in the dental PAHP is not included.

Former Foster Care Children – Individuals under the age 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☒ **PAHP**
☒ **MCO/**PCCM

☒ Mandatory enrollment
☐ Voluntary enrollment

Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matter) consist of Medicaid beneficiaries who are women screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act. Enrollees with conditions such as breast or cervical cancer receive treatment in accordance with the requirements of Section 1504 of that Act. This is to include pre-cancerous condition of the breast or cervix and conditions that are not otherwise covered under creditable coverage, as defined in Section 2701(c) of the Public Health Service Act; are not eligible for Medicaid under any mandatory categorically needy eligibility group; and have not attained age 65.

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment
☐ Voluntary enrollment

Other (Please define)**: In addition to the above groups, the following are also included:**

- Transitional Medical Assistance (42 CFR 435.112) and Medicaid Insurance for Workers with Disabilities.
- Members with additional income that are not intermittently eligible (42 CFR 435.218).
- Deemed Newborns (42 CFR 435.117) Children born to women covered under Medicaid for the date of the child's birth, who are deemed eligible for Medicaid until the child turns age 1.
- Pregnant Women (42 CFR 435.116) Women who are pregnant or post-partum, with household income at or below the states established standard.
- Reasonable Classifications of Children (42 CFR 435.222) Individuals under age 21 who are not mandatorily eligible and who have income at or below the states established standard.
- Children with Non IV-E Adoption Assistance (42 CFR 435.227) Children with special needs for whom there is a non IV-E adoption assistance agreement in effect.
- Medically Needy Pregnant Women (42 CFR 435.301(b)(1)(i) and (iii) Women who are pregnant, who would qualify as categorically needy, except for income.

- Medically Needy Children under age 18 (42 CFR 435.301(b)(1)(ii) Children under age 18 who would qualify as categorically needy, except for income.
- Medically Needy Children under age 19 (42 CFR 435.308) Children over 18, but under age 19 who would qualify as categorically needy, except for income.
- Medically Needy Parents and Other Caretakers (42 CFR 435.310) Parents and other caretakers relatives of dependent children, eligible as categorically needy except for income.
- Parents and Other Caretaker Relatives (42 CFR 435.110) Parents and Other Caretaker Relatives of dependent children with household income at or below the states established standard.
- Infants and Children under Age 19 (42 CFR 435.118) Infants and Children under age 19 with household income at or below the states established standard.
- Presumptive for Pregnant Women (42 CFR 435.1103(a) Women who are pregnant during a presumptive eligibility period following a determination by a qualified entity.
- Hospital Presumptive (42 CFR 435.1110) Individuals who are determined by a qualified hospital to be presumptively eligible.
- Adult expansion population (42 CFR 435.119).
- Refugee population (45 CFR 400.211).
- State Disability population (42 CFR 435.540).

☒ **PAHP**
☒ **MCO/PCCM**

☒ Mandatory enrollment
☐ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **PIHP**
☐ **MCO/PCCM**

Poverty Level Pregnant Women-- Medicaid beneficiaries eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **PIHP**
☐ **MCO/PCCM**

Other Insurance--Medicaid beneficiaries who have other health insurance.

☐ **PIHP**
☐ **MCO/PCCM**

Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) **at custodial levels of care** or in Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐ **PIHP**
☐ **MCO/PCCM**

Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **PIHP**
☐ **MCO/PCCM**

Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ **PIHP**
☐ **MCO/PCCM**

Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **PIHP**
☐ **MCO/PCCM**

American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **PIHP**
☐ **MCO/PCCM**

Children with Special Health Care Needs (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **PIHP**
☐ **MCO/PCCM**

SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

☒ **PAHP ***
☐ **MCO/PCCM**

*This excluded population only applies to the separate CHIP program, "599 CHIP", as the unborn population is excluded from the PAHP. Prenatal ambulatory covered services do not include dental services, as dental services are not considered prenatal ambulatory care.

Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.
☒ **PAHP**
☒ **MCO/PCCM (CSHCN or AI/AN)**

Other (Please define)**: In addition to the above groups, the following are also excluded: Members with retro eligibility past 90 days are excluded from both the MCO and PAHP.**

☒ **PAHP/Dental Benefit Manager**

1) **Aliens who are eligible for Medicaid for an emergency condition only.**
2) **Members with Medicare coverage where Medicaid only pays co-insurance and deductibles.**
3) **Members participating in an approved DHHS PACE program.**
4) **Members who have excess income or who are designated to have a Premium Due and do not have continuous eligibility.**

☒ **MCO**

1) **Aliens who are eligible for Medicaid for an emergency condition only.**
2) **Members who have excess income with intermittent eligibility.**
3) **Members who have received a disenrollment/waiver of enrollment.**
4) **Inmates of Institutions for Mental Disease (i.e., IMD) who are between the ages of 21-64.**
5) **Members participating in an approved DHHS PACE program**
6) **Members who have excess income or who are designated to have a Premium Due and do not have continuous eligibility.**

Medicaid coverage for members excluded from managed care participation remains on a fee-for-service basis. Members who are excluded from managed care cannot voluntarily enroll. Due to changes in a member's Medicaid eligibility and managed care status, a member's status may periodically change. The MCO is responsible for the provision of the benefits package for the member as long as the enrollee is identified as a member of the plan.

F. Services

List all services to be offered under the Waiver in Appendices D2.S., and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

☒ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or **PAHP** programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, **PAHP**, PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable.

If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the **MCO**, PIHP, **PAHP**, or PCCM**.**

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply**.** The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☒ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, insofar as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an **MCO**, PIHP, **PAHP**, PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

The PAHP program will cover dental emergency services only in an outpatient setting (i.e. the dentist's office).

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers, for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

☒ The **MCO**/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.
☐ Other (please explain):
☐ Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☒ The program is **mandatory** and the enrollee is guaranteed a choice of at least one **MCO**/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC: All MCOs are required to contract with existing FQHCs. A member may choose a PCP participating at the FQHC. Access to a non-participating FQHC is not restricted. The MCOs and DBM must offer to contract with all FQHCs and RHCs in the State. If the MCO or DBM cannot contract with the FQHC or RHC, the MCO or DBM must notify MLTC. The DBM must reimburse FQHCs and RHCs in accordance with State Regulations. The MCOs and DBM are required to reimburse the FQHC's at either the State established APM or PPS, and to reimburse the RHC's at the State established PPS.

☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

☒ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

☒ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

Members must access 1915(b)(3) services through their assigned MCO. Approved 1915(b)(3) services are individualized alternative or enhanced services that allow the member to be in the least restrictive and most appropriate level of care, even if these services are non-traditional and do not meet the usual definition of "medical necessity" and are not considered as one of the Nebraska Medicaid covered Behavioral Health services pursuant to State regulations.

1915(b)(3) services under this waiver are the following:

Service	Population Eligible	Provider Type	Geographic Availability	Reimbursement Method
Psychiatric Nursing Services Eligible Medicaid members receives Mental Health Home Health services because they are unable to access office based services. Psychiatric Nursing services are provided at the enrollee's place of residence (excluding hospital, skilled nursing facility, day rehabilitation program, residential rehabilitation facility, or adult day treatment program). Psychiatric nursing services may include services such as assisting the member with co-occurring conditions when the mental health condition exacerbates other health conditions. The Registered Nurse is required to coordinate and communicate with other health care professionals to maintain and improve the member's condition, administering medication, management of medication, and medication teaching, education, ,and assisting the	MCO Adult Enrollees	A Nebraska licensed and enrolled home health agency that employs or contracts with Nebraska licensed registered nurses.	Statewide	Capitation

Service	Population Eligible	Provider Type	Geographic Availability	Reimbursement Method
physical well-being and monitoring of any medication side effects.				
Crisis Treatment and Stabilization Crisis assessment and treatment intervention services are included in the Crisis Treatment intervention provided to a Medicaid eligible member who is in a crisis situation and other individuals who needs emergency outpatient services prior to ongoing services being established. A licensed practitioner can provide Intervention services by completing an initial diagnostic interview brief assessment followed up with a treatment planning. This service provides individual therapy, short-term stabilization, care management, medication management, and mobilization of family and community resources. The licensed practitioner may need to provide intervention services to the member to relieve the acute symptoms and problems associated with their mental health or substance use disorder/ problem. The member may receive crisis services when the services are clinically necessary to relieve a crisis prior to the onset of comprehensive psychiatric; or substance use disorder treatment assessment.	MCO Adult Enrollees	Psychiatrists (M.D.,D.O.), psychologists (Ph.D., Psy.D.), provisionally licensed psychologists (PLP), licensed independent mental health practitioners (LIMHP), licensed mental health practitioners (LMHP), provisionally licensed mental health practitioners (PLMHP) and licensed drug and alcohol counselors (LADC), Provisionally licensed drug and alcohol counselors (PLADC), and advanced practice registered nurses (APRN)	Statewide	Capitation
Adult Intensive Outpatient Includes a mental health or substance use disorder outpatient programs of intensive outpatient mental health services and the more intensive partial hospitalization programs that are non-residential treatment programs which may or may not be hospital based. Admission criteria includes an initial diagnostic interview and, if clinically needed, a substance use disorder assessment prior to entry recommending this level of care. The service includes a structured supervised therapeutic milieu, nursing, ongoing assessment, individual,	MCO Adult Enrollees	Enrolled agencies that employ licensed practitioners who practice within their scope of license. Paraprofessionals may be employed under the supervision of the licensed professionals as outlined by State regulations. Psychiatrists (M.D., D.O.), psychologists (Ph.D., Psy.D), provisionally licensed psychologists (PLP), licensed independent mental health practitioners (LIMHP), licensed mental health	Statewide	Capitation

Service	Population Eligible	Provider Type	Geographic Availability	Reimbursement Method
group and family psychotherapy as well as pycho-educational services and discharge planning. The programs provide diagnostic and treatment, mental health and/or substance use services. These services are at a level of intensity similar to inpatient hospital program but is structured to be outpatient and available less than 24 hours. Treatment services include a structured supervised therapeutic milieu, nursing, psychiatric evaluations, medication management, individual group and family psychotherapy by appropriately licensed professionals. Intensive outpatient mental health or substance use disorder services include psychotherapy by licensed professionals 2-4 times a week 3-6 hours per day. Partial hospitalization includes up to 7 days a week 3-6 hours per day. Recipients must be seen by a physician 3 times a week. The provider must have access to pharmacy, dietary, nursing, psychology and psychotherapy. Additional psychoeducation/psychoeducational services are provided to patients in this setting.		practitioners (LMHP), provisionally licensed mental health practitioners (PLMHP) and licensed drug and Provisionally licensed drug and alcohol counselors (PLADC ,alcohol counselors (LADC), and advanced practice registered nurses (APRN).		
Adult Substance Use Disorder Treatment includes an array of medically necessary substance use treatment services consisting of assessment services, community support, intensive outpatient, partial hospitalization, halfway house, intermediate residential and therapeutic community, short-term residential and dual diagnosis treatment, and substance use social detoxification.	MCO Adult Enrollees	Psychiatrists (M.D., D.O.), psychologists (Ph.D., Psy.D.), provisionally licensed psychologists (PLP), licensed independent mental health practitioners (LIMHP), licensed mental health practitioners (LMHP), provisionally licensed mental health practitioners (PLMHP) and licensed drug and alcohol counselors (LADC), Provisionally licensed drug and alcohol counselors (PLADC , and advanced practice registered nurses (APRN)	Statewide	Capitation

7. **Self-referrals.**

☒ The State requires **MCO**s/PIHPs/**PAHPs**/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the **MCO**/PIHP/**PAHP**/PCCM contract:

- **Emergency services; MCO**
- **Outpatient Dental Emergency services; PAHP**
- **Family Planning; MCOs**
- **FQHC, Rural Health Clinics, Tribal Clinics and Indian Health Services; MCOs and PAHP**

Section A: Program Description

C. **Part II: Access**

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCOs and PAHP programs.**

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, or **PAHP** contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, or PAHP.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM programs**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The State's PCCM-Programs include established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs (please describe):

2. ☐ Specialists (please describe):

3. ☐ Ancillary providers (please describe):

4. ☐ Dental (please describe):

5. ☐ Hospitals (please describe):

6. ☐ Mental Health (please describe):

7. ☐ Pharmacies (please describe):

8. ☐ Substance Abuse Treatment Providers (please describe):

9. ☐ Other providers (please describe):

b. ☐ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Programs include established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs (please describe):

2. ☐ Specialists (please describe):

3. ☐ Ancillary providers (please describe):

4. ☐ Dental (please describe):

5. ☐ Mental Health (please describe):

6. ☐ Substance Abuse Treatment Providers (please describe):

7. ☐ Urgent care (please describe):

8. ☐ Other providers (please describe):

c. ☐ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs (please describe):

2. ☐ Specialists (please describe):

3. ☐ Ancillary providers (please describe):

4. ☐ Dental (please describe):

5. ☐ Mental Health (please describe):

6. ☐ Substance Abuse Treatment Providers (please describe):

7. ☐ Other providers (please describe):

d. ☐ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, or **PAHP** contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM Programs**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b. ☐ The State ensures that there are an **adequate number** of PCCM PCPs with open panels. Please describe the State's standard.

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d. ☐ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM programs and complete the following.

Providers		# In Current Waiver	# Expected in Renewal

e. ☐ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f. ☐ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

g. ☐ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances for MCO, PIHP, or PAHP programs.

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(I) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, or **PAHP** contracts for compliance with the provisions of section 1932(c)(1)(A)(I) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, and PCCM**.**

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

a. ☒ The plan is a PIHP/**PAHP**, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/**PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination**. The DBM is responsible for working with the MCOs to ensure coordination of care for enrollees with special health care needs occurs.**

b. ☒ **Identification**. The State has a mechanism to identify persons with special health care needs to **MCO**s, PIHPs, and PAHPs, and PCCM as those persons are defined by the State. Please describe**. Special health care needs populations are identified within the enrollment file that is sent to the MCOs and the PAHP. Special needs populations are identified as foster care children. The eligibility system does not have the ability to identify medical conditions.**

c. ☒ **Assessment**. Each **MCO**/PIHP/PAHP and PCCM will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by

the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
Upon identification of a person with special health care needs, each MCO plan is required to outreach to the member and complete a health risk assessment to identify ongoing services and need for care management and care coordination. The MCO provides individual assessment, case management, and case tracking for persons with special health care needs. The MCO is required to provide a network of providers that adequately addresses the needs of the member, and to ensure members have direct access to appropriately trained specialists. The PAHP is required to work with the assigned MCO for enrollees which require follow up such as health care needs identified through a dental visit.

d. ☒ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the **MCO**/PIHP/**PAHP** and PCCM to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. ☒ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
   For the PAHP, the dental home will develop the treatment plan
2. ☒ Approved by the **MCO**/PIHP/**PAHP** in a timely manner (if approval required by plan)

3. ☒ In accord with any applicable State quality assurance and utilization review standards.

e. ☒ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the **MCO**/PIHP/**PAHP** and PCCM has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. ☐ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.

b. ☐ Each enrollee in the PCCM program selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. ☐ Each enrollee is receives health education/promotion information. Please explain.

d. ☐ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential exchange of information among providers.

f. ☐ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.

g. ☐ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ☐ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

D. **Part III: Quality**

1. **Assurances for MCO or PAHP programs**.

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, or **PAHP** contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM**.**

☒ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with **MCO**s and **PAHP**s submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PAHPS. The State includes an updated Quality Strategy with this Waiver renewal.

☒ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each **MCO**/ **PAHP** contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO PAHP	Island Peer Review Organization (IPRO) & Health Services Advisory Group (beginning April 1, 2021)	**X** **X**	• Validation of Performance Improvement Projects • Validation of Performance Measures • Review of compliance with Standards outlined in 42 CFR 438.358(b)(3)	• Encounter Validation (MCO Only) • Focus Studies • Administration of consumer Surveys • Network Adequacy Validation

*MLTC complies with 42 CFR Part 438 Subpart E as applicable to MCOs and PAHPs by the applicability dates specified in 42 CFR 438.310(d) and 438.334(a)(3) with the implementation of the Heritage Health contracts and the PAHP/DBM contract. The State contract contains criteria to monitor and to review performance through outcomes of the Quality Performance Program (QPP); EQRO onsite/outcomes, NCQA and URAC ratings results/certifications of the MCO/PHAP; biweekly and quarterly business review meetings with the MCO/PAHP and MLTC.

2. **Assurances for PAHP program.**

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is

an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, **PAHP**, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality improvement guidelines for its PCCM program. Please attach.

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State or its PCCM administrators will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs;
2. ☐ Initiate telephone and/or mail inquiries and follow-up;
3. ☐ Request PCCM responses to identified problems;
4. ☐ Refer to program staff for further investigation;
5. ☐ Send warning letters to PCCMs;
6. ☐ Refer to State's medical staff for investigation;
7. ☐ Institute corrective action plans and follow-up;
8. ☐ Change an enrollee's PCCM;
9. ☐ Institute a restriction on the types of enrollees;
10. ☐ Further limit the number of assignments;
11. ☐ Ban new assignments;
12. ☐ Transfer some or all assignments to different PCCMs;
13. ☐ Suspend or terminate PCCM agreement;

14. ☐ Suspend or terminate as Medicaid providers; and

15. ☐ Other (explain):

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCM's . The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ☐ Has a re-credentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ☐ Initial credentialing

B. ☐ Performance measures, including those obtained through the following (check all that apply):

☐ The utilization management system.
☐ The complaint and appeals system.
☐ Enrollee surveys.
☐ Other (Please describe).

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ☐ Has an initial and re-credentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other (please describe).

d. ☐ Other quality standards (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

E. **Part IV: Program Operations**

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP/PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP/PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, **PAHP**, PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

a. **Scope of Marketing**

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. ☒ The State permits indirect marketing by **MCO**/PIHP/**PAHP**/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP PCCM in general). Please list types of indirect marketing permitted. **With prior approval, MLTC allows the following methods of marketing: Radio, TV, Billboards, Health Fairs, and other methods. Direct Marketing is prohibited.**

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☒ The State prohibits or limits **MCOs**/PIHPs/**PAHPs**/PCCMs/ selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this. **The MCOs contract restricts the MCO from distributing gifts at community events to individuals that are not a member of the MCO. Additionally, gift(s) must not be greater than $15.00 in cash value. The MCOs must notify MLTC of participation in all community events. In addition, the MCOs and PAHP must submit for approval marketing plans and materials. MLTC determines if the MCO or the PAHP has violated any marketing requirements based on the requirements set forth in the contract and the MCO/PAHP will be determined as non-compliant. MLTC expects the MCO/PAHP to present an action plan for the non-compliance.**

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☒ The State requires **MCO**/PIHP/**PAHP**/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):
The MCOs provide member materials in Spanish; the MCOs also provide, upon request, other interpretive services, including braille, upon request.

Pertinent marketing materials such as: **Radio, TV, Billboards, and Health Fairs, with prior-approval by MLTC, are also translated into Spanish and other non-English languages upon request.**

The State has chosen these languages because (check any that apply):

i. ☒ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages. Use of census and other similar information as well as Medicaid participant information. **MLTC determines the State of Nebraska's most prevalent language determined by the census bureau and member demographic information.**

ii. ☐ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii. ☐ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

☒ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, **PAHP**, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM**.**

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

☒ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain): **Spanish**

The State defines prevalent non-English languages as: (check any that apply):

1. ☐ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. ☐ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3. ☒ Other (please explain): **Most prevalent based on Medicaid participant information.**

☒ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken. **The MCOs/PAHP** and the **providers are required to be equipped with appropriate technologies, i.e., TTY/TDD. The EB is also required to provide appropriate technologies.**

☒ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe. **The Enrollment Broker distributes a Member Guidebook to each member and provides choice counseling to the members. The Member Guidebook includes education and important contact information for members. Printed materials are available that describe Heritage Health and DBM. Electronic materials are available at the following link for potential enrollees to view: http://dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx**

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State
☒ Contractor (please specify) **Enrollment Broker**
☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

i. ☐ The State
ii. ☒ State contractor (please specify): **Enrollment Broker and DBM**
iii. ☒ The **MCO**/PIHP/**PAHP**/PCCM**. The EB, MCOs, and DBM contracts contain specific requirements on the required information each entity need to be provide to the members.**

C. Enrollment and Disenrollment

1. **Assurances.**

☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, **PAHP**, and PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, PCCM**.**

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for **MCO**s/PIHPs/**PAHP**/PCCM and FFS selective contracting provider by checking the applicable items below.

a. ☒ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program: **MLTC consistently provides information via the MLTC website, webinars and informational mailings to members, providers, and advocates regarding policy and program changes as needed. The EB provides education and outreach to Managed Care enrollees. The DBM is responsible for outreach to its members.**

The PAHP developed a Cultural Competency Plan (CCP) in 2017. The objectives of the CCP are to:

- **Ensures services are provided in a culturally competent manner to all members from diverse cultural and ethnic backgrounds, including those with limited English proficiency and visual and hearing impairments.**

- **Provide members access to quality dental services that are culturally and linguistically sensitive by identifying trends in the member population. Ensure that all member materials complete both an internal and an external review process before they reach the member population.**
- **Conduct needs assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.**
- **Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity, and primary language spoken.**
- **Ensure that providers recognize and care for the culturally diverse needs of the population.**
- **Ensure that staff at all levels and across the organization receives ongoing training in culturally and linguistically appropriate service delivery.**

b. **Administration of Enrollment Process**.

☐ State staff conducts the enrollment process.

☒ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☒ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

The EBS meets statutory independence requirements.

Broker name: **Automated Health Systems**

Please list the functions that the contractor will perform:

☒ choice counseling
☒ enrollment
☐ other (please describe):

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

☐ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.): The DBM is a single dental plan that Medicaid will implement statewide all at once.

☐ Heritage Health was the expansion of an existing Managed Care program during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☒ If a potential enrollee **does not select** an **MCO**/PAHP or PCCM within the given period, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. ☒ Potential enrollees will have **0 days** to choose a plan.
ii. ☒ Please describe the auto-assignment process and/or algorithm. In the description, please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an **MCO**/PIHP/**PAHP**/PCCM who is their current provider or who is capable of serving their particular needs.

For the Heritage Health program, MLTC focused the design of the auto-assignment process to maintain family relationships with the same MCO, maintain member/PCP relationships, maintain historical MCO relationships and balance member enrollment among the three MCO's.

Below is a summary of the auto-assignment algorithm in order of priority:

- **MCO family relationship**
  - **Reviewed/assigned on member basis**
  - **Will consider other family member choices/assignments**
  - **If MCO tie, assign to plan of closest in age family member**
- **Historical MCO relationship**
  - **Members are assigned based on historical relationship with an MCO**
  - **Reviewed/assigned on member basis**
- **Historical PCP/provider relationship**
  - **Reviewed/assigned on member basis**
  - **If MCO tie, member will be assigned to MCO with highest number of provider relationships for the member**
- **Equitable distribution among MCOs**
  - **Reviewed/assigned on family basis**
  - **Members assigned to MCO with fewest members**
  - **If MCO's member counts are tied, alternate distribution among MCOs**

☒ The State **automatically enrolls** beneficiaries

- ☐ On a mandatory basis into a single MCO or PAHP in a rural area (please also check item A.I.C.3)
- ☒ On a mandatory basis into a single **PAHP** for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- ☐ On a voluntary basis into a single MCO or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:

  _____
- ☐ Other:

☐ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an **MCO**/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☒ The State **automatically re-enrolls** a beneficiary with the same PCCM or **MCO**/**PAHP** if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

☒ The State allows enrollees to disenroll from/**transfer** between **MCOs**/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. ☒ Enrollee submits request to State/Enrollment Broker.
ii. ☐ Enrollee submits request to MCO/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
iii. ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☒ The State **does not permit disenrollment** from a single PIHP/**PAHP** (authority under 1902 (a) (4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☒ The State has a **lock-in** period (i.e. requires continuous enrollment with **MCO**/PAHP/PCCM) of **_12_** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

- **The MCO does not cover the service the enrollee requests because of moral or religious objections.**
- **An authorized provider determines that an enrollee must receive related services simultaneously (example: A cesarean section and a tubal ligation) that are not available within the plan's network.**
- **Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.**

☐ The State **does not have a lock-in**, and enrollees in MCOs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request. Enrollees in the PIHP are allowed to change providers at any time.

☒ The State permits **MCOs**/PAHPs **to request disenrollment** of enrollees. Please check items below that apply:

i. ☒ **MCO**/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

- **There is sufficient documentation to establish that another MCO would better treat the member's condition or illness.**
- **There is sufficient documentation to establish fraud or forgery or evidence of unauthorized use/abuse of managed care services by the member.**
- **The State's contract with the MCOs does not allow MCOs to request disenrollment because of a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-exiting medical condition; refusal of medical care or diagnostic testing; uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the MCO's ability to furnish services to the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise her/her**

right to change, for cause, the PCP that he/she chose or was assigned. (42 CFR 438.56(b)(2)).

ii. ☒ The State reviews and approves all **MCO**/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☒ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the **MCO**/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. ☒ The enrollee remains an enrollee of the **MCO**/PIHP/PAHP/PCCM-until another **MCO**/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee Rights

1. **Assurances.**

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or** more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO**, PIHP, **PAHP**, PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b) (4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, **MCO**s, PIHPs, **PAHPs**, and States in PCCM, and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

☒ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances for MCO or PAHP programs. MCOs/PAHPs** are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO** or **PAHP** contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the **MCO**, PIHP, **PAHP**, or PCCM.

3. **Details for MCO or PAHP programs**.

a. **Direct access to fair hearing**.

☒ The State **requires** enrollees to **exhaust** the MCO or PAHP grievance and appeal process before enrollees may request a state fair hearing.

☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

☒ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **60** days (between 20 and 90).

☒ The State's timeframe within which an enrollee must file a **grievance** is **at any time**.

c. **Special Needs**

☐ The State has special processes in place for persons with special needs. Please describe.

4. **Optional grievance systems for PCCM, and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its PCCM, and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

☐ The grievance procedures is operated by:

- ☐ the State
- ☐ the State's contractor. Please identify: _____
- ☐ the PCCM
- ☐ the PAHP.

☐ Please describe the types of requests for review that can be made in the PCCM, and/or PAHP grievance system (e.g. grievance, appeals).

☐ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

☐ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: (please specify for each type of request for review).

☐ Has time frames for resolving requests for review. Specify the time period set: (please specify for each type of request for review)

☐ Establishes and maintains an expedited review process for the following reasons:

☐ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision**.**

☐ Other (please explain):

F. Program Integrity

1. **Assurances.**

☒ The State assures CMS that is complies with section 1932(d) (1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an **MCO,** PCCM, PIHP, or **PAHP** from knowingly having a relationship with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

3. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
4. A person with beneficial ownership of five percent or more of the MCO, PCCM, PIHP, or PAHP equity;
5. A person with an employment, consulting, or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☒ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude an entity that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. Precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
   c. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
   d. Employs or contracts directly or indirectly with an individual or entity that is precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   e. Could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances for MCO or PIHP programs**

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☒ State payments to an MCO or PAHP are based on data submitted by the MCO or PAHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified and 42 CFR 438.606 Source, Content, and Timing of Certification.

☐ The State seeks a waiver of a waiver of section 1902(a) (4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

☒ The CMS Regional Office has reviewed and approved the **MCO** or **PAHP** contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs.

However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. States must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

F. Part I. Summary Chart of Monitoring Activities

Quality Performance Program (QPP) is to monitor and evaluate the quality and appropriateness of the health care the Health Plans, members and ensure they receive the highest quality of care, preventive health services and achieve the highest level of outcomes. Information is provided by the Plans from the QPP measures. Ares that are being monitored are, claims processing timeliness-15 days; encounter acceptance rate; call abandonment rate; appeal resolution timeliness; PDL compliance; lead screening in children; well child visits in the first 15 months of life; and childhood immunizations status. This information comes directly from the reports submitted from the Plans on a monthly and quarterly basis and the daily encounter files from MMIS via.

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

A. **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

B. **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

C. **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enrollment/ Disenrollment*	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
a. Accreditation for Non-Duplication					MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
b. Accreditation for Participation						MCO						MCO
c. Consumer Self-Report Data – CAHPS	MCO	MCO	MCO	MCO	MCO PAHP	MCO PAHP	MCO PAHP	MCO	MCO PAHP	MCO PAHP	MCO	MCO PAHP
c. Consumer Self-Report Data – Member Satisfaction Survey												
d. Data Analysis (non-claims)	MCO		MCO	MCO		MCO PAHP	MCO PAHP	MCO	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP
e. Enrollee Hotlines	MCO		MCO		MCO	MCO PAHP						
f. Focused Studies												
g. Geographic mapping	MCO						MCO PAHP	MCO PAHP		MCO	MCO PAHP	
h. Independent Assessment												
i. Measure any Disparities by Racial or Ethnic Groups								MCO PAHP	MCO PAHP			MCO PAHP
j. Network Adequacy Assurance by Plan	MCO		MCO				MCO PAHP	MCO PAHP		MCO	MCO PAHP	MCO

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enrollment/ Disenrollment*	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
k. Ombudsman	MCO PAHP			MCO PAHP		MCO PAHP				MCO PAHP		
l. On-Site Review	MCO PAHP	MCO PAHP		MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP		MCO
m. Performance Improvement Projects					MCO PAHP		MCO		MCO	MCO PAHP		MCO PAHP
n. Performance Measures							MCO PAHP		MCO	MCO PAHP		MCO PAHP
o. Periodic Comparison of Providers												
p. Profile Utilization by Provider Caseload												
q. Provider Self-Report Data -Provider Survey						MCO PAHP	MCO PAHP		MCO PAHP	MCO PAHP		
r. Test 24/7 PCP Availability												
s. Utilization Review									MCO PAHP	MCO PAHP		MCO PAHP

*The State is requesting a waiver of section 1902(a)(4) of the Act which requires States to offer a choice of more than one PAHP. Members will automatically be enrolled into the single statewide PAHP. As such, the State system is responsible for the enrollment/disenrollment for the PAHP so there is no monitoring activities that occur, as the contractor does not perform these activities.

B. **Part II. Details of Monitoring Activities**

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

C. Applicable programs (if this waiver authorizes more than one type of managed care program)
D. Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
E. Detailed description of activity
F. Frequency of use
G. How it yields information about the area(s) being monitored

a. ☒ Accreditation for Non-Duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

☒ NCQA
☐ JCAHO
☐ AAAHC
☒ Other (please describe)**: URAC for the PAHP**

MCO accreditation certifications are located at the following link (very last item on the page): http://dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx

PAHP accreditation certification is located at the following link (under general information): http://dhhs.ne.gov/Pages/Medicaid-Dental-Benefits-Manager.aspx

- **Nebraska Total Care – NCQA certified from 02/25/2022 to 02/25/2025 2 as Accredited.**

- **UnitedHealthcare Community Plan – NCQA certified from 08/17/2020 to 8/17/2023 as Commendable and URAC certified from 8/17/2020 to 8/17/2023.**

- **HealthyBlue Nebraska – NCQA certified from *11/12/2021 to 11/12/2024* as Accredited.**
- **Managed Care of North America, Inc (Dental) –URAC certified from 12/01/2020 to 12/01/2023 as full Accreditation.**

b. ☒ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

☒ NCQA
☐ JCAHO
☐ AAAHC
☒ Other (please describe): **URAC for the PAHP**

c. ☒ Consumer Self-Report Data

☒ CAHPS (please identify which one(s)):
The MCO's will use the most current version of the Adult and Child Medicaid Questionnaire
☐ State-developed survey
☐ Disenrollment survey
☐ Consumer/beneficiary focus groups

CAHPS

H. Applicable programs: **MCO, DBM**
I. Personnel responsible: **MCO or DBM Staff**
J. Detailed description of activity: **MLTC requires the use of the most recent version of the Adult and Child NCQA Consumer Assessment of MCO Survey (CAHPS).**
K. Frequency of use: **Annually**
L. How it yields information about the area(s) being monitored:

a. The survey is used to monitor:

i. Choice
ii. Marketing
iii. Enrollment/Disenrollment
iv. Program Integrity
v. **Information to Beneficiaries**
vi. **Grievances**
vii. **Timely Access**
viii. **PCP/Specialist Capacity**
ix. **Coordination/Continuity of Care**
x. **Coverage/Authorization**
xi. **Provider Selection**
xii. **Provider Quality of Care**

The survey responses are analyzed to create the CAHPS composite (basic information regarding access, availability and provider competence) and to measure member satisfaction with care. MLTC utilizes this to identify issues for performance improvement projects and to create a comparative chart that is delivered to potential members.

d. ☒ Data Analysis (non-claims)

- ☐ Denials of referral requests
- ☒ Disenrollment requests by enrollee
  - ☒ From plan
  - ☒ From PCP within plan
  - ☒ Grievances and appeals data
  - ☒ PCP termination rates and reasons
  - ☐ Other:

M. Applicable programs: **MCO and DBM**

N. Personnel responsible: **MCO; DBM Staff and State Staff**

O. Detailed description of activity: **Staff track disenrollment reasons and analyze for trends. MCOs and the DBM are required to submit quarterly management reports related to timely access, PCP/Specialist capacity, and provider selection. State staff analyzes the data to ensure that the plans are meeting their requirements.**

P. Frequency of use: **Annually, per quality assurance file review cycle or ongoing as self-reports are received.**

Q. How it yields information about the area(s) being monitored:

a. Results are used to monitor:

1. **Choice**
2. **Enrollment/Disenrollment**
3. **Grievances**
4. **Program Integrity**
5. **PCP/Specialist Capacity**
6. **Timely Access**
7. **Coordination/Continuity**
8. **Coverage/Authorization**
9. **Provider Selection**
10. **Quality of Care**

The State will reach out to the Plan when clarification is required.

e. ☒ Enrollee Hotlines Operated by State

R. Applicable programs: **MCO and DBM.**

S. Personnel responsible: **Automated Health Systems (AHS) is the Medicaid Enrollment Broker.**

T. Detailed description of activity: **Automated Health Systems - Reporting and tracking of member grievances and appeals, member initiated plan transfer requests, and handles annual open enrollment activities. The enrollment broker accepts the request of disenrollment from the enrollees outside of the enrollment period and documents the information in enrollment broker system. The request for disenrollment is sent to**

MLTC staff to review to make a determination utilizing the State's regulations specifically related to a for cause transfer. The enrollment broker monitors the type and number of request for trend.

U. Frequency of use: **Monthly**

V. How it yields information about the area(s) being monitored:

a. **AHS will share helpline statistics with the State on a Monthly basis so the State can monitor the following:**

i. **Choice**
ii. **Enrollment/Disenrollment**
iii. **Information to Beneficiaries**
iv. **Grievances**

The State will provide the results to the MCOs and DBM for appropriate follow up.

f. ☐ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. ☒ Geographic Mapping of Provider Network

W. Applicable programs: **MCO and DBM**

X. Personnel responsible: **MCO and DBM**

Y. Detailed description of activity: **Through geographic mapping and reporting. MCO staff identifies the provider type distribution across the State. Examples of MCO provider types shown through mapping include primary care providers, specialists, hospitals, urgent care providers, and ancillary providers. The DBM has similar requirements based on relevant provider types.** The MCOs and DBM must maintain a network of qualified providers that meets appointment availability and geographic access standards.

Z. Frequency of use: **Quarterly**

AA. How it yields information about the area(s) being monitored: **Geographic mapping information is used to monitor:**

a. Choice
b. Timely Access
c. PCP/Specialist Capacity
d. Coverage/Authorization
e. Provider Selection

Reports are created from geo-mapping software programs that the State analyzes for compliance with access requirements. The analysis is part of the quarterly report submitted to the State. State staff and other stakeholders discuss the findings to identify opportunities for improvement. If deficiencies are noted, MCO and DBM must conduct corrective action until they are compliant.

h. ☐ Independent Assessment of Program Impact, Access, Quality, and Cost-Effectiveness (Required for first two waiver periods)

i. ☒ Measurement of Any Disparities by Racial or Ethnic Groups

BB. Applicable programs: **MCO and DBM**
CC. Personnel responsible: **MCO and DBM Staff**
DD. Detailed description of activity: **Each MCOs and the DBM must submit documentation to the State that proves network adequacy requirements such as provider access of more than one PCP that is multi-lingual and culturally diverse. The MCOs and the DBM must also report on the HEDIS measure Race/Ethnicity Diversity of Membership.**
EE. Frequency of use: **Quarterly for network reports; Annually for HEDIS measure**
FF. How it yields information about the area(s) being monitored: **Network reports and HEDIS measure provide information on:**

1. **PCP/Specialist Capacity**
2. **Coordination/Continuity of Care**
3. **Quality of Care**

The State addresses disparity issues with the MCOs and DBM as the need arises based on information the MCOs and DBM submit to the State. The State compares MCO and DBM reported information against the strategies developed by the Nebraska DHHS Office of Minority Health.

j. ☒ Network Adequacy Assurance Submitted by Plan [Required for **MCO**/PIHP/**PAHP**]

GG. Applicable programs: **MCO and DBM**
HH. Personnel responsible: **MCO and DBM Staff**
II. Detailed description of activity: **MCOs and the DBM submits documentation to the State showing what the network offers and the appropriate range of services relative to the anticipated number of enrollees demonstrating that the network is sufficient to meet the needs of enrollees in terms of number, mix, and geographic distribution of providers.**
JJ. Frequency of use: **Quarterly**
KK. How it yields information about the area(s) being monitored:

- **a. Network reports provide information on:**
  - **i. Choice**
  - **ii. Enrollment/Disenrollment**
  - **iii. Timely Access**
  - **iv. PCP/Specialist Capacity**
  - **v. Coverage/Authorization**
  - **vi. Provider Selection**

vii. Quality of Care

The State addresses network adequacy issues with the MCOs and DBM as needed.

k. ☒ Ombudsman

LL. Applicable programs: **MCO and DBM**
MM. Personnel responsible: **State Staff**
NN. Detailed description of activity: **The DHHS Office of the System Advocate responds to questions, concerns, and complaints from consumers, service providers, elected officials, and interested citizens related to services, programs, and operations within the Health and Human Services System.**
OO. Frequency of use: **Annually**
PP. How it yields information about the area(s) being monitored:

a. System Advocate reports provide information for the monitoring of:

i. Choice
ii. Program Integrity
iii. Grievances
iv. Coverage/Authorization

The System Advocate provides regular reports to the Governor, Legislature, and DHHS Partnership Council. It is also available on the DHHS Web site. The report summarizes with the number and types of contacts received by the office, geographical area of contacts, subject of contacts, and referrals for contacts.

l. ☒ On-Site Review

QQ. Applicable programs: **MCO and the DBM**
RR. **Personnel responsible: EQRO and State Staff**
SS. **Detailed description of activity:**
TT. **EQRO/IPRO review:**

Island Peer Review Organization (IPRO/EQRO) provided the 2020 annual external quality review and Health Services Advisory Group Inc. will continue to provide the upcoming annual external quality review (EQRO), with a full spectrum of healthcare assessments and improvement services that foster the efficient use of resources and enhance healthcare quality to achieve better patient outcomes. EQRO preforms an annual EQR for each of the Heritage Health MCOs. The report details each MCO`s EQRO activities; description of each MCO`s review methodology, assessments of the MCO`s strength and weakness to quality, timeliness, and access; recommendations for improving quality of health services; assessments of the MCO`s responses to recommendations during EQROs; and Plan- specific and aggregated reports.

UU. **State On-site and reviews:**

State Staff perform annual On-site reviews of the MCOs to obtain additional information regarding compliance with federal regulations, contracts, and quality improvement activities. On-site reviews are in-depth summaries of the findings from the Plans On-site visits that are conducted annually by authorized State employees. The areas reviewed during the On-sites are, overviews of the MCOs general operations, financial records, and quality reviews. The State provides the MCO`s recommendations for improving quality of health services and contractual requirements.

VV. Frequency of use: **Annually**

WW. How it yields information about the area(s) being monitored:

a. Reports of on-site reviews provide information for the monitoring of:

i. Choice
ii. Marketing
iii. Program Integrity
iv. Information to Beneficiaries
v. Grievances
vi. Timely Access
vii. PCP/Specialist Capacity
viii. Coordination/Continuity of Care
ix. Coverage/Authorization
x. Quality of Care

On-site reviews include reviewing contract terms, monthly and quarterly reports with plan to identify issues and develop plans of action.

m. ☒ Performance Improvement Projects [Required for MCO/PIHP]

☒ Clinical
☒ Non-Clinical

XX. Applicable programs: **MCO and DBM**

YY. Personnel responsible: **MCO and DBM Staff**

ZZ. Detailed description of activity: **The MCOs must conduct a minimum of two clinical and one non-clinical PIP's. A minimum of one (1) clinical issue must address an issue of concern to the MCO population, which would likely have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIP's are required to meet all the requirements of CMS. The MCO`s submitted PIPs to the State prior to implementation with the relevant CMS requirements and it was approved by the State. The State identified at a minimum that the MCO`s have to jointly participate.**

The following MCO PIPs were completed during 2017- 2020:

1. Clinical PIPs include: Improving Tdap rates in pregnant women;

AAA. **Behavioral Health Clinical PIP includes: Follow up after ED visit for Mental Health/Substance Use Disorder; and**

BBB. **Joint PIP:**

1) **The MCOs developed the following new PIP: UHC** Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

CCC. **Dental PIP:**

The DBM must conduct a minimum of one clinical and one non-clinical PIP. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation. The PAHP (dental) PIPs continued to be the Annual Dental Visit (ADV) and the Preventative Dental Visit (Pdent).

DDD. Frequency of use: **Annually**

EEE. How it yields information about the area(s) being monitored: **Chosen projects enable the MCO to better monitor:**

a. Information to Beneficiaries
b. Timely Access
c. Coordination/Continuity of Care
d. Coverage/Authorization
e. Quality of Care

The MCOs and DBM submit updates and results for the PIP's to State staff to assess appropriateness of applied interventions and identify additional interventions towards improvement. The MCO's, DBM, Quality Committee, and the State, with input from the EQRO, will decide new PIP study areas.

n. ☒ Performance Measures [Required for MCO/PAHP]

- ☐ Process
- ☒ Health Status/Outcomes
- ☒ Access/Availability of Care
- ☒ Use of Services/Utilization
- ☐ Health Plan Stability/Financial/Cost of Care
- ☐ Health Plan/Provider Characteristics
- ☒ Beneficiary Characteristics

FFF. Applicable programs: **MCO and DBM**

GGG. Personnel responsible: **MCO Staff and DBM Staff**

Detailed description of activity: **The MCOs report on the Healthcare Effectiveness Data and Information (HEDIS) measures and the Child and Adult Health Care Quality Measures' Child and Adult Core sets. All reporting will follow the specifications, reporting requirements, and measure listings for the relevant reporting year as determined by the guidelines set forth by the measure set's stewards. Attachment B will contain a full listing of the measures required, as of reporting year 2021.**

The DBM will report HEDIS, CHIPRA core measures, and Dental Quality Alliance measures related to Dental:

a. PDENT

b. Annual Dental Visit

1. Frequency of use: **Annually**
2. How it yields information about the area(s) being monitored:

HHH. **Results of performance measures enable MCO and DBM to monitor: Timely Access Coordination/Continuity, Coverage/Authorization and Quality of Care.**

a. The MCO/DBM provides data annually as indicated in the Heritage Health contract and DBM contract in compliance with 438.330(b)(3) as part of the QAPI program performance measures. Under and over utilizations are included as a part of the overall data review and QAPI program.

b. The state uses baseline data to establish benchmarks and goals. The State compares the data to national results. The MCO's and DBM will discuss results with the State, Quality Committee, and EQRO staff to determine future actions. Possible future actions include focus areas that may become a PIP, continued monitoring by an alternate method, or discontinuing an action that addressed an issue. The MCO and DBM must document the results to improve the quality of care and member's health outcomes.

o. ☐ Periodic Comparison of Number and Types of Medicaid Providers Before and After Waiver

p. ☐ Profile Utilization by Provider Caseload (looking for outliers)

q. ☒ Provider Self-Report Data
☒ Survey of Providers
☐ Focus Groups

III. Applicable programs: **MCO and DBM**

JJJ. Personnel responsible: **MCO and DBM Staff**

Detailed description of activity: **The MCO`s and DMB must conduct an annual provider survey to assess provider's satisfaction with the following: provider credentialing, service authorization, staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management process including medical reviews and support for PCMH implementation. The plans must submit the provider survey to**

MLTC for approval at least 90 calendar days prior to intended administration. The methodology used by the plans must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of minimum of 95% and scaling that results in a clear positive or negative findings (neutral response categories shall be avoided).

Frequency of use: **Annually**

KKK. How it yields information about the area(s) being monitored:

- **a. The survey is used to monitor:**
  - **i. Grievances**
  - **ii. Timely Access**
  - **iii. Coordination/Continuity**
  - iv. **Coverage/Authorization**

The State will review the results annually to track MCO performance in relation to satisfaction of the providers in the MCO network.

r. ☐ Test 24 Hour/7 Days a Week PCP Availability

LLL. Applicable programs:
MMM. Personnel responsible:
NNN. Detailed description of activity: Frequency of use:
OOO. How it yields information about the area(s) being monitored:

s. ☒ Utilization Review (e.g. ER, non-authorized specialist requests)

PPP. Applicable programs: **MCO and DBM**
QQQ. Personnel responsible: **MCO and DBM Staff**
RRR. Detailed description of activity:

- **a. The MCO's report on the following measures: HEDIS measures, CHIPRA measures, and Adult core measures.**
- **b. The DBM will report the data and analysis summarizing the DBM's annual evaluation of the UM program.**

SSS. Frequency of use: **Annually**
TTT. How it yields information about the area(s) being monitored:

- **a. This process yields information and is part of the monitoring oversight for:**
  - **i. Coordination/Continuity**
  - **ii. Coverage/Authorization**
  - **iii. Quality of Care**

The State uses the utilization review process to ensure that the plans are observing appropriate criteria for the approval and denial of care. If the State identifies issues, these issues are communicated to the plan for corrective action and follow up.

t. ☐ Other (please describe)**:**

1. How it yields information about the area(s) being monitored:

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

☐ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

☒ This is a renewal request.

- ☐ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ☒ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:
Strategy:
Confirmation it was conducted as described:

☐ Yes
☐ No. Please explain:

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

a. ☒ Accreditation for Non-Duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

☒ NCQA
☐ JCAHO
☐ AAAHC
☒ Other (please describe): URAC

Summary of results:

- **Nebraska Total Care – NCQA certified from 02/25/2022 to 02/25/2025 as Accredited.**
- **UnitedHealthcare Community Plan – NCQA certified from 08/17/2020 to 08/17/2023 as Commendable and URAC certified from 08/01/2020 to 08/17/2023.**
- **HealthyBlue Nebraska – NCQA certified from *11/12/2021 to 11/12/2024* as Accredited.**
- **Managed Care of North America (Dental) – NCQA certified from 07/09/2019 to 07/09/2022 as credentialing and re-credentialing and URAC certified from 12/01/2020 to 12/01/2023 as full accreditation.**

Problems identified: **None**
Corrective action (plan/provider level): **None**
Program change (system-wide level): **None**

b. ☒ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

☒ NCQA
☐ JCAHO
☐ AAAHC
☒ Other (please describe): **URAC**

Strategy:

- **MCO accreditation certifications are located at the following link (very last item on the page): http://dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx**

- **PAHP accreditation certification is located at the following link (under general information): http://dhhs.ne.gov/Pages/Medicaid-Dental-Benefits-Manager.aspx**

Confirmation it was conducted as described:
☒ Yes
☐ No. Please explain:
Summary of results: **Certification obtained by the MCO and DBM.**
Problems identified: **None**
Corrective action (plan/provider level): **None**
Program change (system-wide level): **None**

c. ☒ Consumer Self-Report Data

☒ CAHPS (please identify which one(s)): **(for MCOs)**

Strategy:

- **2020 Adult Medicaid Questionnaire**
- **2021 Adult Medicaid Questionnaire**
- **2020 Child Medicaid Questionnaire**
- **2021 Child Medicaid Questionnaire**

☒ State-developed survey: Consumer Satisfaction Survey (for **PAHP**)
☐ Disenrollment survey
☐ Consumer/beneficiary focus groups

- Confirmation it was conducted as described: **All MCOs CAHPS surveys**
  ☒ Yes
  ☐ No. Please explain:

- Summary of results: **A NCQA certified vendor performs CAHPS according to HEDIS technical specifications, including survey instrument, sample size, sampling method, collection protocols and CAHPS component of the HEDIS compliance audit.**

CAHPS Survey Results Percentile Rating Responses				
Adult 2020	UHC	WHP	NTC	Comments
Personal doctor an 8, 9, or 10	88.90%	92.00%	87.90%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	86.20%	87.80%	85.60%	
All health care received an 8, 9, or 10	81.90%	85.70%	80.60%	
Rating of health plan an 8, 9, or 10	84.30%	82.50%	86.30%	
Adult 2021	UHC	HBN	NTC	Comments
Personal doctor an 8, 9, or 10	84.70%	87.25%	89.30%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	85.00%	88.89%	85.90%	
All health care received an 8, 9, or 10	78.80%	78.82%	84.00%	
Rating of health plan an 8, 9, or 10	82.00%	75.25%	84.60%	
Child General Population 2020	UHC	WHP	NTC	Comments
Personal doctor an 8, 9, or 10	93.70%	87.70%	93.10%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	91.30%	93.50%	86.20%	
All health care received an 8, 9, or 10	89.10%	89.00%	92.30%	
Rating of health plan an 8, 9, or 10	87.90%	86.60%	91.60%	
Child General Population 2021	UHC	HBN	NTC	Comments
Personal doctor an 8, 9, or 10	97.30%	90.88%	90.30%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	91.40%	84.00%	93.10%	
All health care received an 8, 9, or 10	94.00%	88.17%	89.00%	
Rating of health plan an 8, 9, or 10	89.60%	82.39%	89.20%	
Child CCC Population 2020	UHC	WHP	NTC	Comments
Personal doctor an 8, 9, or 10	92.40%	93.40%	90.40%	
Specialist seen most often an 8, 9, or 10	84.20%	90.50%	83.30%	• Problems identified: None - no separate CCC national average is available for 2020.
All health care received an 8, 9, or 10	87.60%	90.30%	83.60%	• Corrective action (plan/provider level): None.
Rating of health plan an 8, 9, or 10	83.90%	90.60%	82.90%	• Program change (system-wide level): None.
Child CCC Population 2021	UHC	HBN	NTC	Comments
Personal doctor an 8, 9, or 10	93.70%	93.89%	92.30%	
Specialist seen most often an 8, 9, or 10	87.30%	84.78%	84.30%	• Problems identified: None - no separate CCC national average is available for 2021.
All health care received an 8, 9, or 10	90.10%	91.77%	90.10%	• Corrective action (plan/provider level): None.
Rating of health plan an 8, 9, or 10	86.10%	82.72%	83.90%	• Program change (system-wide level): None.
CHIP General Population 2020	UHC	WHP	NTC	Comments
Personal doctor an 8, 9, or 10	93.90%	92.80%	91.70%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	97.00%	82.20%	93.80%	
All health care received an 8, 9, or 10	93.00%	86.60%	89.40%	
Rating of health plan an 8, 9, or 10	91.00%	90.40%	91.40%	
CHIP General Population 2021	UHC	HBN	NTC	Comments
Personal doctor an 8, 9, or 10	95.30%	93.59%	92.50%	• Problems identified: The four questions used to score Overall Performance is at or above the national average for all four questions. The four questions used are rating of personal doctor, rating of specialist, rating of all health care, and rating of MCO. • Corrective action (plan/provider level): None. Overall performance remained at or above the national average for all four questions. • Program change (system-wide level): None.
Specialist seen most often an 8, 9, or 10	96.70%	85.19%	93.30%	
All health care received an 8, 9, or 10	92.40%	90.71%	88.70%	
Rating of health plan an 8, 9, or 10	92.80%	89.05%	86.90%	
CHIP CCC Population 2020	UHC	WHP	NTC	Comments
Personal doctor an 8, 9, or 10	87.70%	91.70%	91.80%	
Specialist seen most often an 8, 9, or 10	93.90%	85.40%	87.50%	• Problems identified: None - no separate CCC national average is available for 2020.
All health care received an 8, 9, or 10	83.70%	90.60%	86.80%	• Corrective action (plan/provider level): None.
Rating of health plan an 8, 9, or 10	86.60%	90.90%	85.70%	• Program change (system-wide level): None.
CHIP CCC Population 2021	UHC	HBN	NTC	Comments
Personal doctor an 8, 9, or 10	92.00%	93.49%	95.50%	
Specialist seen most often an 8, 9, or 10	94.30%	84.29%	90.90%	• Problems identified: None - no separate CCC national average is available for 2021.
All health care received an 8, 9, or 10	91.30%	90.39%	87.50%	• Corrective action (plan/provider level): None.
Rating of health plan an 8, 9, or 10	89.70%	88.66%	82.40%	• Program change (system-wide level): None.

- Strategy: Developed Survey- Consumer Satisfaction Survey **CAHPS Adult Dental Satisfaction Survey and Child Satisfaction Survey based on CAHPS methodology and format.**

- Confirmation it was conducted as described:
  ☒ Yes
  ☐ No. Please explain:

- Summary of results:
  In 2019, MCNA completed 689 member satisfaction surveys and achieved an overall score of 97.77%. There were no trends identified and each category exceeded goal.

A total of 220 Member Satisfaction Surveys were completed for 2020 and the overall satisfaction rate was 96.52%, far exceeding the goal of 90%. Member Services quality assurance results were 95.52% accuracy for the year exceeding the goal of 90%.

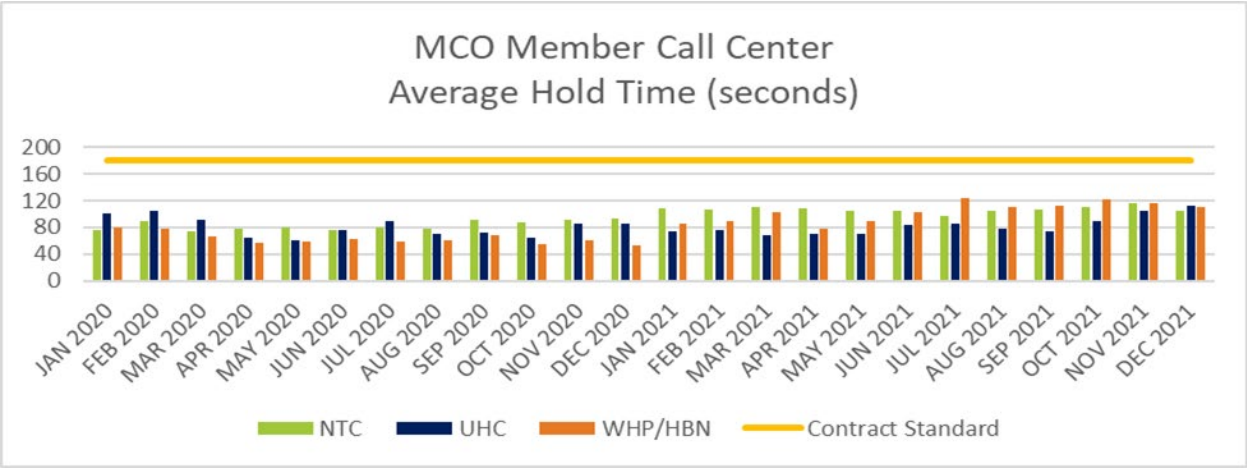
d. ☒ Data Analysis (non-claims)
  ☐ Denials of referral requests
  ☒ Disenrollment requests by enrollee
    ☒ From plan
    ☒ From PCP within plan
    ☒ Grievances and appeals data
    ☒ PCP termination rates and reasons
    ☐ Other:

- Strategy: **MCO and PAHP Data Analysis**
- Confirmation it was conducted as described:
  ☒ Yes
  ☐ No. Please explain:

- Summary of results:
  - EBS reported member's request to transfer for MCOs were low for the State Fiscal Year 2018-2019. Members have 90 days after initial enrollment to change their managed care plan.

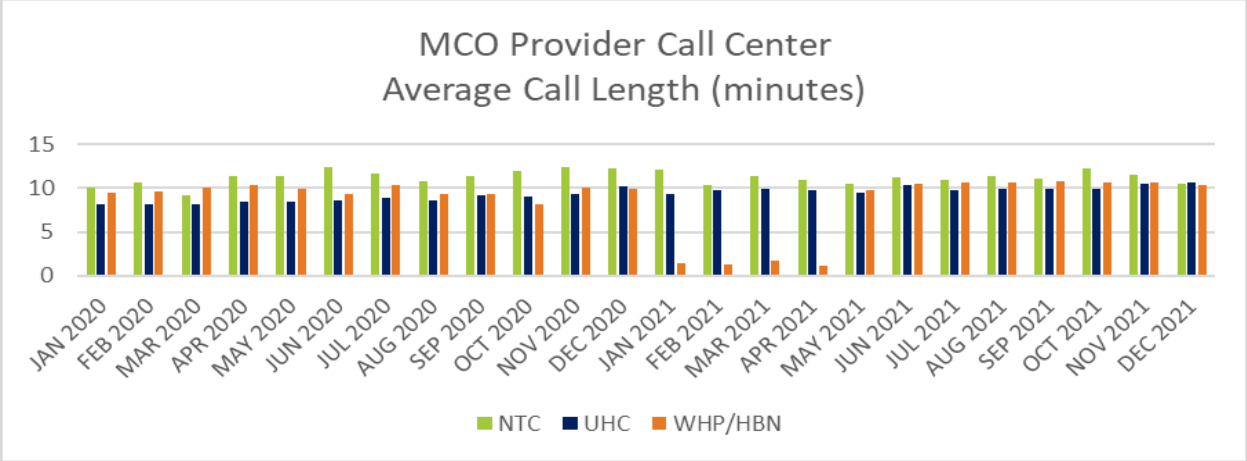
  - **The Heritage Health MCOs met the contracted Member Call Center Average Hold Time (in seconds) and provided data for the Average Call Length (in minutes) for 2020 to 2021:**

Note: The data in the following two charts are for WellCare for 2020, and Healthy Blue for 2021. Healthy Blue took over for WellCare beginning in January of 2021.

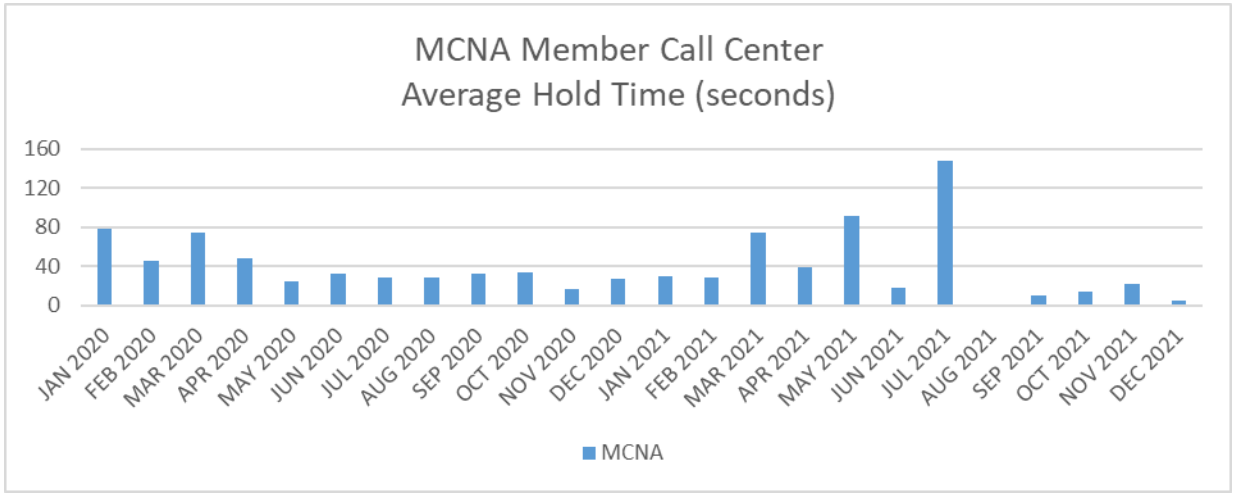


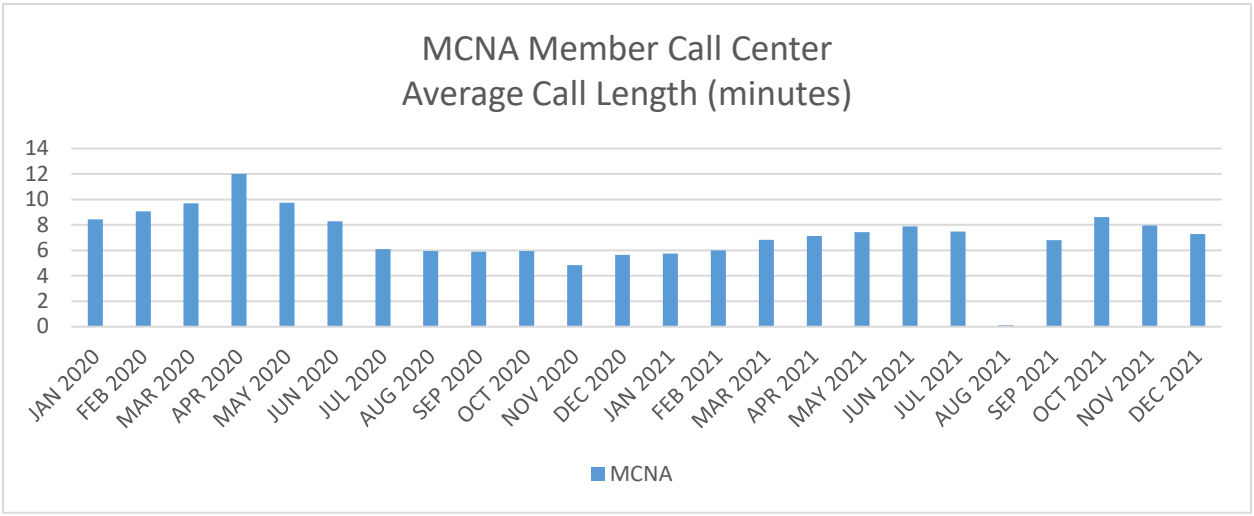
- **The Heritage Health MCOs met the contracted Provider Call Center Average Hold Time (in seconds) and provided data for the Average Call Length (in minutes) for 2020 to 2021:**

  Note: The data in the following two charts are for WellCare for 2020, and Healthy Blue for 2021. Healthy Blue took over for WellCare beginning in January of 2021.

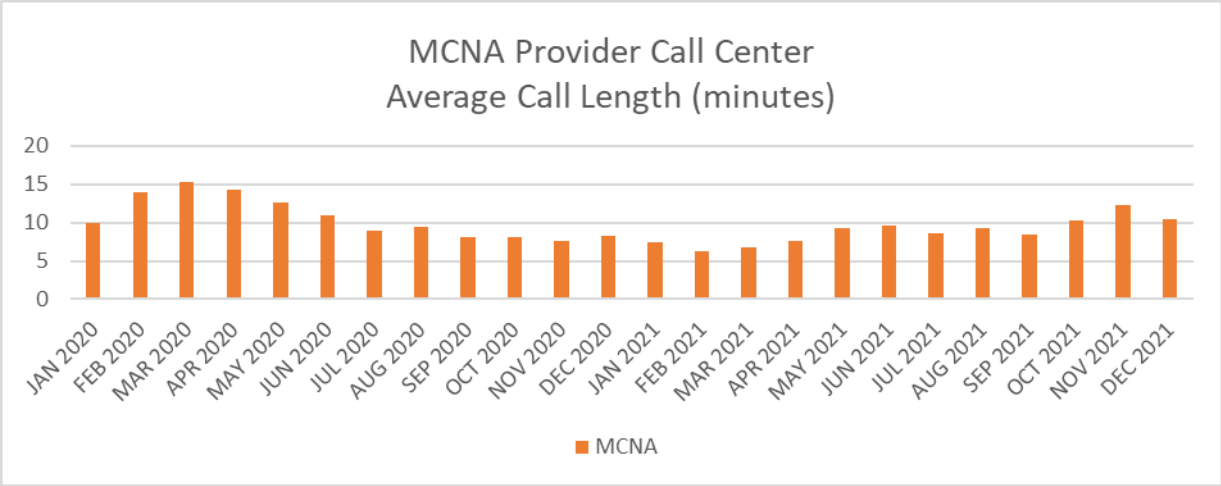


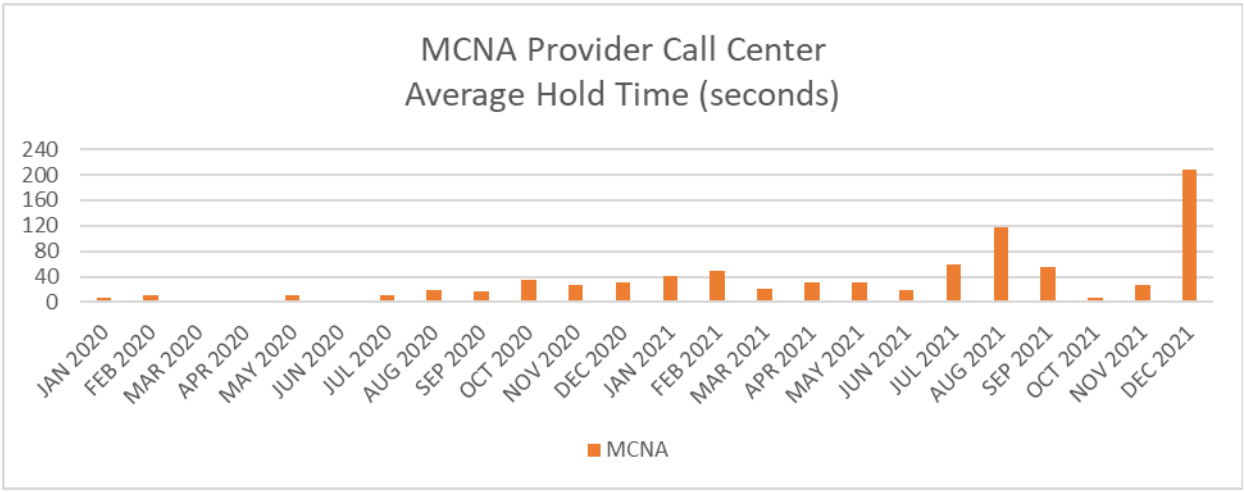
- **MCNA provided data for the Member Call Center Average Call Length (in minutes) and the Average Hold Time (in seconds) for 2020 to 2021:**





- **MCNA provided data for the Provider Call Center Average Call Length (in minutes) and the Average Hold Time (in seconds) for 2020 to 2021:**



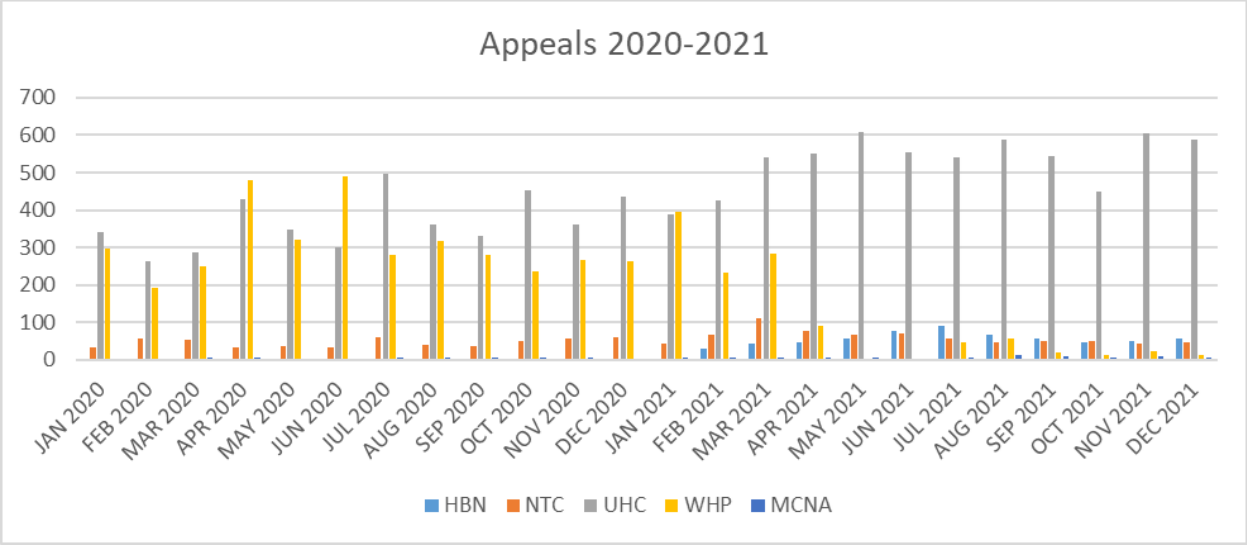


- **Appeals Data for 2020 - 2021:**

  The top reasons reported for appeals in 202-2021 were claims payment, authorization, and provider reimbursement issues. The Heritage Health MCOs and DBM in 2020 had 8,656 total appeals. The data reported by the Heritage Health MCOs and DBM in 2020 shows 8,954 total appeals.

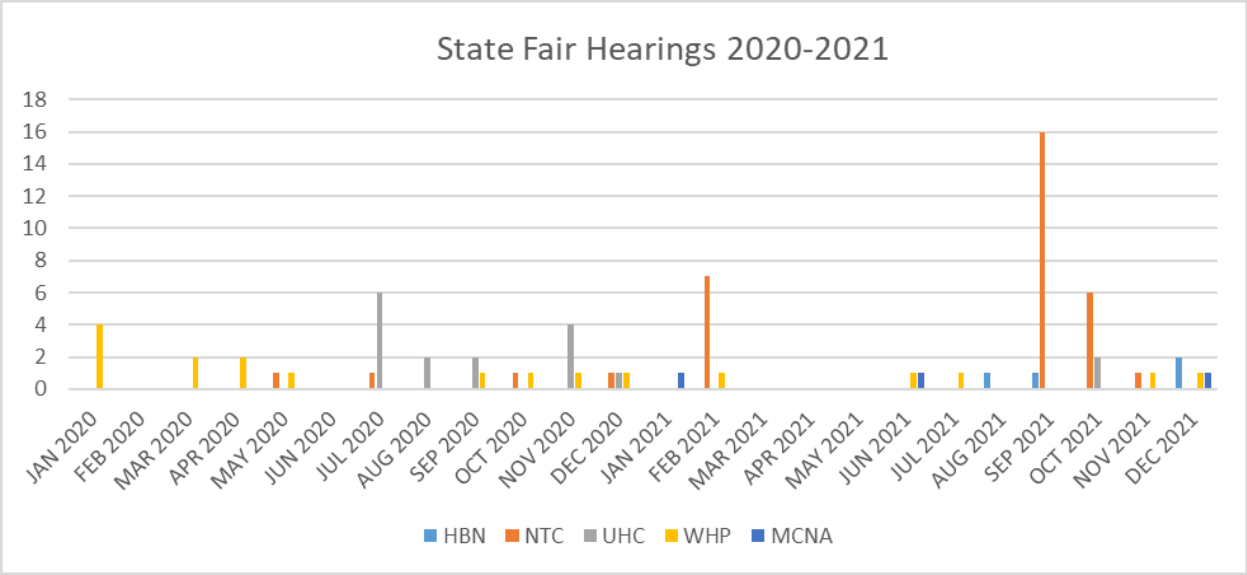
  - WellCare: 2020 = 3,666 total appeals and 2021 = 1,168 total appeals
  - Nebraska Total Care: 2020 = 50 total appeals and 2021 = 722 total appeals

- UnitedHealthcare Community Plan: 2020 = 4,399 total appeals and 2021 = 6,380 total appeals
- MCNA/DBM: 2020 = 41 total appeals and 2021 = 72 total appeals



- **State Fair Hearing data for 2020-2021:**

The data indicates there were low numbers of State Fair Hearing requested. The majority of the dismissals were for non-appealable issues or no previous appeal completed. Each of the MCOs' provider manuals contains educational information and educational materials are located for both providers and members on the MCOs' websites. The data shows the number of State Fair Hearing resolved for each of the MCOs:



- The MCOs and DBM reports from 2020-2021 showed no trends for PCP terminations and the most frequent reported reasons were leaving the practice or moving to another location.

  - Problems identified: **No significant problems were identified.**
  - Corrective action (plan/provider level**): None**
  - Program change **(**system-wide level): **None**

e. ☒ Enrollee Hotlines Operated by State

- Strategy: **Enrollment Broker Helpline Report**
- Confirmation it was conducted as described:

  ☒ Yes

  ☐ No. Please explain:

Summary of results: **HHEB Queue Statistics by Calendar Year**

The Heritage Health Medicaid Enrollment broker contract was awarded to Automated Health Systems. The new HH program expanded mandatory Medicaid managed care statewide to Medicaid members deemed eligible for Heritage Health. Enrollment (Implementation) into the new program began 9/1/2016. HH members had until 12/15/16 to voluntarily choose a plan; those who chose a plan and those who were auto- assigned to a plan because they did not choose a plan by 12/15/16 were enrolled in one of three participating MCOs effective 1/1/2017.

The following chart presents Heritage Health Enrollment Broker Queue statistics by calendar years 2019, 2020, and 2021.

- Problems identified: **No significant problems were identified.**
- Corrective action (plan/provider level**): None**
- Program change **(**system-wide level): **None**

AHS Statistics by Calendar Year 2019 - 2021

Period	Inbound English	Inbound Spanish	Total Calls Offered	Calls Handled	Average Abandon Rate	Abandon Rate SLA	% Calls Non-HH Related	Average Wait Time (ASA) (min)	Wait Time (ASA) SLA (min)	Average Hold Time (sec)	Hold Time SLA (sec)
2019	**9,259**	**772**	**10,031**	**9,803**	**2.27%**	**5%**	**7%**	**0:00:19**	**2.00**	**0:04:33**	**30**
2020	**6,843**	**541**	**7,384**	**7,068**	**4.28%**	**5%**	**8%**	**0:00:30**	**2.00**	**0:00:13**	**30**
2021	**6,549**	**524**	**7,073**	**6,923**	**2.12%**	**5%**	**8%**	**0:00:22**	**2.00**	**0:00:11**	**30**

- The Enrollment broker (EB) met all SLA in 2019 and 2020 for Heritage Health related calls and unrelated Heritage Health enrollment calls from member that were transferred to DHHS and other entities.

f. ☐ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. ☒ Geographic Mapping of Provider Network

- Strategy: **MCO and PAHP Reporting**
- Confirmation it was conducted as described:
  - ☒ Yes
  - ☐ No. Please explain:

- Summary of results:
  - **Reports are regularly submitted on a quarterly basis.**

- Problems identified: **The rural parts of the State have low density of population and overall in these areas there is a lack of behavioral health providers. All three MCOs credential and contract with providers in the bordering states, as well as offer Telehealth services to members in these areas.**
- Corrective action (plan/provider level): **None.**
- Program change (system-wide level): **None.**

h. ☐ Independent Assessment of Program Impact, Access, Quality, and Cost-Effectiveness (Required for first two waiver periods)

i. ☒ Measurement of Any Disparities by Racial or Ethnic Groups

- Strategy: **MCO and PAHP Reporting**
- Confirmation it was conducted as described:
  - ☒ Yes
  - ☐ No. Please explain:
- Summary of results**: All three MCOs have provider panels in 2020-2021 that offered adequate access to PCPs who are multi-lingual. HEDIS data for race indicates that over half of the member membership is White or African American. The MCO`s have an adequate panel of providers that are multi-lingual. The MCO`s developed a 2018 Cultural Competency Plan and the plan contained goals to enhance, collaborate, and educate families and consumers regarding cultural competency as well as health disparities.**

1) Problems identified: **None**
2) Corrective action (plan/provider level): **None**
3) Program change (system-wide level): **None**

j. ☒ Network Adequacy Assurance Submitted by Plan [Required for MCO/PIHP/PAHP]

- Strategy: **MCO and PAHP Reporting**
- Confirmation it was conducted as described:
  - ☒ Yes
  - ☐ No. Please explain:
- Summary of results:

Quarterly the State receives a network adequacy reports from HealthyBlue/WellCare of Nebraska, Nebraska Total Care and UnitedHealthcare Community Plan. The MCOs as well as the DBM provide an annual Network Plan to MLTC for approval.

The results include: GeoAccess report submittal, and Timely Access Reporting.

- **The MCO Healthy Blue/WellCare, in 2020-2021 reported the following results:**

Healthy Blue/WellCare Geo Access	*Urban*	*# of Providers*	*Rural*	*# of Providers*	*Frontier*	*# of Providers*
2020 PCP	**Standard 30 miles**		**Standard 45 miles**		**Standard 60 miles**	
2021 PCP	**Standard 30 miles**	6191	**Standard 45 miles**	1908	**Standard 60 miles**	378
2020 Specialist – Other	**Standard 30 miles**		**Standard 45 miles**		**Standard 60 miles**	

2021 Specialist – Other	**Standard 30 miles**		**Standard 45 miles**		**Standard 60 miles**	
2020 Specialists - High Volume	**Standard 90 miles**		**Standard 90 miles**		**Standard 90 miles**	
2021 Specialists - High Volume	**Standard 90 miles**	6764	**Standard 90 miles**	436	**Standard 90 miles**	39
2020 Pharmacy	**Standard 5 miles**		**Standard 15 miles**		**Standard 60 miles**	
2021 Pharmacy	**Standard 5 miles**	310	**Standard 15 miles**	174	**Standard 60 miles**	16
2020 Facilities/Ancillary	**Standard 30 miles**		**Standard 45 miles**		**Standard 60 miles**	
2021 Facilities/Ancillary	**Standard 30 miles**	284	**Standard 45 miles**	30	**Standard 60 miles**	0
2020 Hospitals	**Standard 30 minutes**		**Standard 45 miles**		**Standard 60 miles**	
2021 Hospitals	**Standard 30 minutes**	51	**Standard 45 miles**	93	**Standard 60 miles**	21
2020 Behavioral Health	**Standard 30 miles**		**Standard 45 miles**		**Standard 60 miles**	
2021 Behavioral Health	**Standard 30 miles**	8679	**Standard 45 miles**	523	**Standard 60 miles**	42

Healthy Blue/WellCare reported the following results in the2021 Annual Network Plan:

Type of Care	Availability Standard	% Met 2020	% Met 2021
Primary Care Providers			
Emergency	**24 hours/day, 7 days/week**	**99.0296.6%**	**96.38.7%**
Urgent Care	**Same Day**	**93.9882.9%**	**91.8182.7%**
Family Planning	**7 Calendar days**	**93.776.7%**	**88.310.1%**
Preventative Care (non-urgent)	**28 Calendar days**	**97.7596.6%**	**92.206.5%**
Non-Urgent Sick Care	**72 Hours**	**97.785.2%**	**96.229%**
Specialists (High-Volume)			
Routine	**30 Calendar days**	**96.4588.3%**	**91.924.1%**
Prenatal			
First Trimester	**14 Calendar days**	**96.5182.5%**	**912.606.9%%**
Second Trimester	**7 Calendar days**	**94.2687.7%**	**82.5892.3%**
Third Trimester	**3 Calendar days**	**89.7557.9%**	**73.9682.2%**
High Risk	**3 Calendar days**	**76.0058.8%**	**89.0689.5%**
Lab and X-Ray Services			
Routine	**21 Calendar days**	**90.273.3%**	**0 responses89.5%**
Urgent Care	**48 Hours**	**90.273.3%**	**0 responses100%**

Time Availability			
One Medical Doctor	20 hours/week	100.0%	96.370%
Two or more Medical Doctors	30 hours/week	10099.2%	92.169.5%

- **The MCO Nebraska Total Care reported the following results in 2020-2021:**

NTC Geo Access	*Urban*	*# of Providers*	*Rural*	*# of Providers*	*Frontier*	*# of Providers*
2020 PCP	Standard 30 miles	102,028	Standard 45 miles	19,483	Standard 60 miles	2,218
2021 PCP	Standard 30 miles	113,850	Standard 45 miles	21,561	Standard 60 miles	2,384
2020 Specialist – Other	Standard 30 miles	15,456	Standard 45 miles	1,800	Standard 60 miles	347
2021 Specialist – Other	Standard 30 miles	15,936	Standard 45 miles	1,623	Standard 60 miles	372
2020 Specialists - High Volume	Standard 90 miles	423	Standard 90 miles	181	Standard 90 miles	18
2021 Specialists - High Volume	Standard 90 miles	5,336	Standard 90 miles	669	Standard 90 miles	36
2020 Pharmacy	Standard 5 miles	312	Standard 15 miles	110	Standard 60 miles	17
2021 Pharmacy	Standard 5 miles	326	Standard 15 miles	164	Standard 60 miles	27
2020 Facilities/Ancillary	Standard 30 miles	1,197	Standard 45 miles	598	Standard 60 miles	199
2021 Facilities/Ancillary	Standard 30 miles	1,398	Standard 45 miles	781	Standard 60 miles	127
2020 Hospitals	Standard 30 minutes	40	Standard 45 miles	50	Standard 60 miles	11
2021 Hospitals	Standard 30 minutes	40	Standard 45 miles	50	Standard 60 miles	11
2020 Behavioral Health	Standard 30 miles	7,141	Standard 45 miles	881	Standard 60 miles	47
2021 Behavioral Health	Standard 30 miles	7,696	Standard 45 miles	943	Standard 60 miles	56

Nebraska Total Care reported the following from the Quarterly reports in 2020-2021:

NTC: Type of Care	Availability (AV) Standard	% of Providers That Met The AV Standard (2020 Average %)	% of Providers That Met The AV Standard (2021 Average %)
Physician/Care			
Emergency	24 hours/day, 7 days/week	74.02	

Urgent Care	Same Day	97.05	
Family Planning	7 Calendar days	94.92	
Preventative Care (non-urgent)	28 Calendar days	99.02	
Non-Urgent Sick Care	72 Hours	96.13	
Specialists (High-Volume)			
Routine	30 Calendar days	97.47	
Prenatal			
First Trimester	14 Calendar days	98.91	
Second Trimester	7 Calendar days	98.74	
Third Trimester	3 Calendar days	90.54	
High Risk	3 Calendar days	96.47	
Lab and X-Ray Services			
Routine	21 Calendar days	99.92	
Urgent Care	48 Hours	99.79	
Time Availability			
One Medical Doctor	20 hours/week	98.40	
Two or more Medical Doctors	30 hours/week	99.21	

- **UnitedHealthcare Community Plan, in 2020-2021 reported the following results:**

UHCCP Geo Access	*Urban*	*# of Providers*	*Rural*	*# of Providers*	*Frontier*	*# of Providers*
2020 PCP	**Standard 30 miles**	**4303**	**Standard 45 miles**	**858**	**Standard 60 miles**	**196**
2021 PCP	**Standard 30 miles**	**3500**	**Standard 45 miles**	**785**	**Standard 60 miles**	**119**

2020 Specialist – Other	**Standard 30 miles**	**10726**	**Standard 45 miles**	**1645**	**Standard 60 miles**	**174**
2021 Specialist – Other	**Standard 30 miles**	**10925**	**Standard 45 miles**	**1669**	**Standard 60 miles**	**165**
2020 Specialists - High Volume	**Standard 90 miles**	**4283**	**Standard 90 miles**	**528**	**Standard 90 miles**	**48**
2021 Specialists - High Volume	**Standard 90 miles**	**4324**	**Standard 90 miles**	**505**	**Standard 90 miles**	**34**
2020 Pharmacy	**Standard 5 miles**	**627**	**Standard 15 miles**	**231**	**Standard 60 miles**	**34**
2021 Pharmacy	**Standard 5 miles**	**331**	**Standard 15 miles**	**120**	**Standard 60 miles**	**18**
2020 Facilities/Ancillary	**Standard 30 miles**	**804**	**Standard 45 miles**	**206**	**Standard 60 miles**	**16**
2021 Facilities/Ancillary	**Standard 30 miles**	**808**	**Standard 45 miles**	**190**	**Standard 60 miles**	**20**
2020 Hospitals	**Standard 30 minutes**	**26**	**Standard 45 miles**	**50**	**Standard 60 miles**	**12**
2021 Hospitals	**Standard 30 minutes**	**37**	**Standard 45 miles**	**50**	**Standard 60 miles**	**11**
2020 Behavioral Health	**Standard 30 miles**	**9635**	**Standard 45 miles**	**1425**	**Standard 60 miles**	**91**
2021 Behavioral Health	**Standard 30 miles**	**9481**	**Standard 45 miles**	**1288**	**Standard 60 miles**	**103**

UnitedHealthcare Community Plan reported the following results in 2020-2021Annual Network Plan:

UHCCP: Type of Care	Availability Standard	% Met 2020	% Met 2021
Primary Care Providers			
Emergency	24 hours/day, 7 days/week	97%	96.4%
Urgent Care	Same Day	100%	100%
Family Planning	7 Calendar days	100%	100%
Preventative Care (non-urgent)	28 Calendar days	100%	100%
Non-Urgent Sick Care	72 Hours	100%	100%
Specialists (High-Volume)			
Routine	30 Calendar days	100%	100%
Prenatal			
First Trimester	14 Calendar days	100%	100%
Second Trimester	7 Calendar days	100%	100%
Third Trimester	3 Calendar days	100%	100%
High Risk	3 Calendar days	100%	100%
Lab and X-Ray Services			

Routine	21 Calendar days	100%	100%
Urgent Care	48 Hours	100%	100%
Time Availability			
One Medical Doctor	20 hours/week	100%	100%
Two or more Medical Doctors	30 hours/week	100%	100%

- **Managed Care of North America in 2020-2021 reported the following results:**

2020

Geo Access	Urban	# of Providers	Rural	# of Providers	Frontier	# of Providers
Dentists	Standard 45	707	Standard 60	209	Standard 100	8
Specialist - Oral Surgeons	Standard 45	36	Standard 60	3	Standard 100	1
Specialists - Orthodontist	Standard 45	29	Standard 60	4	Standard 100	0
Specialists - Periodontist	Standard 45	10	Standard 60	0	Standard 100	0
Specialists - Pedodontist	Standard 45	97	Standard 60	6	Standard 100	0

2021

Geo Access	Urban	# of Providers	Rural	# of Providers	Frontier	# of Providers
Dentists	Standard 45	828	Standard 60	221	Standard 100	8
Specialist - Oral Surgeons	Standard 45	32	Standard 60	2	Standard 100	0
Specialists - Orthodontist	Standard 45	35	Standard 60	5	Standard 100	0
Specialists - Periodontist	Standard 45	14	Standard 60	0	Standard 100	0

Specialists - Pedodontist	Standard 45	111	Standard 60	8	Standard 100	0

A. Problems identified: **None**
B. Corrective action (plan/provider level): **None**
C. Program change (system-wide level): **None**

k. ☒ Ombudsman
D. Strategy: State Staff-Systems Advocate
E. Confirmation it was conducted as described:
☒ Yes
☐ No. Please explain:
F. Summary of results: **No managed care concerns reported by the System Advocate**
G. Problems identified: **None**
H. Corrective action (plan/provider level): **None**
I. Program change (system-wide level): **None**

l. ☒ On-Site Review
J. Strategy: **EQRO, State Staff**
K. Confirmation it was conducted as described:
☒ **Yes**
☐ No. Please explain:
L. Summary of results:

The EQRO conducted the three mandatory EQR activities for WellCare of Nebraska, Nebraska Total Care, and UnitedHealthcare Community Plan 2019-2020:

M. Validation of performance improvement projects (PIPs)
N. Validation of performance measures reported by the MCO
O. Review to determine MCO compliance with access to care, and structure and operations standards established by the State

The MCO's accreditation status and accreditation outcome were reviewed by the EQRO as part of the non-duplication EQRO activities outlined in the State's Quality Improvement Strategy. Note: summaries of Performance Improvement Projects and performance measure reviews conducted by the EQRO are listed below under each of those topics. For each MCO and DBM, a description is provided, including: content reviewed, current year findings and recommendations, and MCO and DBM response and action plan. EQRO will assess the effectiveness of the MCO and DBM's actions during the next annual compliance review.

Summary of the compliance designations by category of standard reveals:

Healthy Blue of Nebraska (Formerly WellCare) Review Year 2019-2020

Standards	**Compliance Designation**	Performance Domain
Care Management	Full Compliance	Access
Provider Network	Full Compliance	Access
Provider Services	Partial Compliance	Quality
Subcontracting	Full Compliance	Quality
Member Services and Education	Full Compliance	Quality
Quality Management	Partial Compliance	Quality
Utilization Management	Full Compliance	Quality and Timeliness
Grievances and Appeals	Partial Compliance	Quality and Timeliness

The Access domain includes HEDIS MY 2019 performance and findings from two (2) of the eight (8) compliance domains: Care Management and Provider Network and were found fully compliant.

HEDIS MY 2019 Performance for Access:

For HEDIS MY 2019, Healthy Blue/WellCare performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months),
- Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years),
- Children and Adolescents' Access to Primary Care Practitioners (7–11 years),
- Children and Adolescents' Access to Primary Care Practitioners (12–19 years), and
- Adults' Access to Primary Care Providers (20–44 Years and 45–64 Years).

The MCO performed **below** the national Medicaid HMO averages for:

- Adults' Access to Primary Care Providers—65+ years, and
- Ambulatory Care—ED Visits/1,000 MM (note for this measure, a lower rate is desirable).

Of note, the rate for Access to Primary Care Providers—65+ years was **at** the national Medicaid 5th percentile, and Adults' Access to Primary Care Providers—20–44 Years rate was **at or above** the national Medicaid 90th percentile.

The Quality domain contained Provider services, Subcontracting, Member Services and Education, Quality Management. Healthy Blue received full compliance for Subcontracting, Member Services and Education and Utilization.

HEDIS MY 2019 Performance for Quality:
For HEDIS MY 2019, Healthy Blue performed **better than** the national Medicaid HMO averages for:

- Adolescent Immunization – Combo 1, and
- Childhood Immunizations – Combination 10,

In the Timeliness domain Healthy Blue received full compliance for Utilization Management.

HEDIS MY 2019 Performance for timeliness:
For HEDIS MY 2019, Healthy Blue performed **better than** the national Medicaid HMO averages for:

- Cervical Cancer Screening,
- Comprehensive Diabetes Care—Retinal Exam,
- Comprehensive Diabetes Care—HbA1c Measurement,
- Follow-up for ADHD Medication—Initiation,
- Follow-up for ADHD Medication—Continuation,
- Timeliness of Prenatal Care,
- Well-Child Visits 0–15 Months, 6+ Visits, and
- Adolescent Well-Care Visits.

P. Problems identified: **The EQRO compliance review found the following:**

In the Quality domain, Healthy Blue received a designation of partial compliance for Provider Services, Quality Management, and Grievances and Appeals (note the standards determined to be substantial for Grievances and Appeals relate to timeliness, not quality, and thus are not reflected in this section).

Provider Services: IPRO reviewed five (5) standards / sub-standards for Provider Services, four (4) were fully compliant and one (1) was partially compliant. The following details the findings from the review of this partially compliant standard:

- Nine (9) of 10 provider appeal files demonstrated evidence of timely resolution. One (1) file exceeded the 30-calendar-day turnaround time.

Quality Management: A total of thirty-seven (37) standards /sub-standards were reviewed. Of those, Thirty-four 34 standards were fully compliant out of the thirty-seven (37) standards /sub-standards, two (2) were partially compliant, and one (1) was not applicable. The following details findings from the review of partially compliant standards:

- Amendment 7 of the Heritage Health contract required that all CMS Adult and Child Core Set measures be reported. MLTC provided a reporting template for the MCOs, with the understanding that it would need to be updated each year to reflect the required measure set. Healthy Blue did not submit all required measures.
- The Quality Performance Measurement and Evaluation requirement is partially evidenced in the four PIP reports submitted (for the new HEDIS SSD PIP and the three projects that started in 2018: Tdap, 17P, and Follow-Up After ED Visit for Mental Health Illness/Substance Use Disorder), as well as in the Adult and Child Core Set measure summaries and the HEDIS MY 2018 workbook.

Grievance and Appeal:
IPRO reviewed three (3) standards/sub-standards that were reviewed for Grievances and Appeals, all three (3) were partially compliant. The following details findings from the review of the partially compliant standards:

- Of the 20 grievance files reviewed for this requirement, eighteen (18) files met the requirement for timeliness of acknowledgement and the remaining two (2) files did not meet the requirement for acknowledgement in writing within ten (1)0 calendar days of receipt. For both files, the acknowledgement letter was dated more than ten (10) calendar days after the MCO received the request.
- Of the ten (10) appeals files reviewed, five (5) files were not applicable for this requirement as they were expedited appeals. Of the 5 remaining standard appeals, three (3) files met the requirement and two (2) files did not meet the requirement. For both files, the acknowledgement letter was dated more than ten (10) calendar days after the MCO received the request.
- Of the five (5) expedited appeals files reviewed, four (4) files met the requirement and the remaining one (1) file did not meet the requirement. With regard to the one (1) file that did not meet the requirement, the acknowledgement letter was dated 7/13/2020, which was outside of the review period. The MCO received the request on 5/21/2019. At the virtual compliance review, the MCO explained that this finding is accurate; a coordinator did not mail the acknowledgement letter to the member at the time the appeal was received.
- Post virtual onsite, IPRO requested the MCO submit proof of submission of the grievance logs to MLTC during the review period. As proof of submission of Grievances and Appeals Logs, the MCO submitted emails sent to MLTC on Thursday, September 10, 2020. This date was outside of the review period.

The Timeliness domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Utilization Management, and Grievances and Appeals.
Healthy Blue received a designation of partial compliance for Grievances and Appeals.

In the domain of Timeliness, IPRO recommends that Healthy Blue:

- make a reasonable effort to ensure that acknowledgment letters for grievances and appeals are sent to members/providers within the required timeframe of 10 calendar days. This includes continuing to train staff on grievances and appeals policies and protocols for timely acknowledgment and following internal workflows and processes for processing grievances and appeals;
- resolve each expedited appeal within the required timeframe of 72 hours after receipt, and train appropriate staff on the processes and procedures related to resolution of expedited Appeals;
- submit proof of submission of Grievances and Appeals Logs to MLTC within the review period in question to satisfy this requirement; and develop interventions to specifically target performance for those HEDIS MY 2019 measures that are at or below the national Medicaid HMO average

HealthyBlue reported HEDIS rates **below** the national Medicaid HMO averages for Quality domain:

- Child/Adolescent BMI Assessment,
- Child/Adolescent Counseling for Nutrition,
- Child/Adolescent Counseling for Physical Activity,
- Human Papillomavirus Vaccine for Female Adolescents,
- Medication Management for People with Asthma (Total)—75%,
- Lead Screening in Children,
- Childhood Immunizations—Combination 2,
- Childhood Immunizations—Combination 3,
- Comprehensive Diabetes Care BP < 140/90,
- Controlling High Blood Pressure,
- Use of Imaging for Low Back Pain,
- Antidepressant Medication Management—Effective Acute Phase, and
- Antidepressant Medication Management—Effective Continuation Phase.

Of note, the rates for Adult BMI Assessment, Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, Child/Adolescent Counseling for Physical Activity, Medication Management for People with Asthma (Total)—75%, and Controlling High Blood Pressure were **at or below** the national Medicaid 10th percentile.

In the domain of Quality, IPRO recommended that Healthy Blue:

- ensure all provider claims disputes are resolved within 30 calendar days, per their policies and procedures;
- ensure that, going forward, if all CMS Adult and Child Core Set measures continue to be required, they appear in the workbooks and reports submitted to MLTC; and

- develop interventions to specifically target performance for those HEDIS MY 2019 measures that are at or below the national Medicaid HMO average.

Nebraska Total Care Review Year 2019-2020

Standards	Compliance Designation	Performance Domain
Care Management	Full Compliance	Access
Provider Network	Full Compliance	Access
Provider Services	Partial Compliance	Quality
Subcontracting	Full Compliance	Quality
Member Services and Education	Full Compliance	Quality
Quality Management	Partial Compliance	Quality
Utilization Management	Full Compliance	Quality and Timeliness
Grievances and Appeals	Full Compliance	Quality and Timeliness

The Access domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Care Management and Provider Network. The EQRO/IPRO found NTC in full compliance.

HEDIS MY 2019 Performance for the domain of access:

For HEDIS MY 2019, NTC performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, 7–11 years, and 12–19 years); and
- Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years).

The MCO reported a rate below the national Medicaid HMO average for Ambulatory Care—ED Visits/1,000 MM.

Of note, the rates for Adults' Access to Primary Care Providers (20–44 Years and 45–64 Years) were at or above the national Medicaid 95th percentile.

The Timeliness domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Utilization Management, and Grievances and Appeals.

HEDIS MY 2019 Performance

For HEDIS MY 2019, NTC performed **better than** the national Medicaid HMO averages for:

- Pharmacotherapy Management of COPD—Systemic Corticosteroid,
- Pharmacotherapy Management of COPD—Bronchodilator,
- Cervical Cancer Screening,
- Well-Child Visits 0–15 Months, 6+ Visits,
- Comprehensive Diabetes Care—Retinal Exam, and

- Follow-up for ADHD Medication—Continuation.

Problems identified: The EQRO compliance review found the following:
The Quality domain encompasses PIP activities, HEDIS MY 2019 performance, and findings from six of the eight compliance domains: Member Services and Education, Provider Services, Grievances and Appeals, Quality Management, Subcontracting, and Utilization Management. NTC received a designation of partial compliance for Provider Services and Quality Management.

Provider services – Quality

- Of the five (5) standards/sub-standards reviewed for Provider Services, three (3) were fully compliant and two (2) were partially compliant. The following details findings from the review of these partially compliant standards:
    - There is an opportunity in the Provider Manual to communicate with providers the process for in-person complaints.
    - The MCO must develop an internal claims dispute process for claims that have been denied or underpaid.

In the domain of Quality, IPRO recommends that NTC:

- communicate to providers (e.g., in the Provider Manual or the provider portal) the process they have in place for in-person complaints;
- ensure provider appeals/claims disputes are resolved in accordance with the timelines reflected in NTC's policies and procedures;
- going forward, if all CMS Adult and Child Core Set measures continue to be required, MCO should ensure these measures appear in the workbooks and reports submitted to MLTC.
- include next steps for each PIP in the QI Work Plan, so that the MCO has a high-level framework to guide their actions for the subsequent project year.

Quality Management - Quality
IPRO reviewed thirty-nine (39) standards/sub-standards reviewed for Quality Management, thirty-five (35) were fully compliant, three (3) were partially compliant, and one (1) was not applicable. The following details findings from the review of the partially compliant standards:

- Amendment 7 of the Heritage Health contract required that all CMS Adult and Child Core Set measures be reported. MLTC provided a reporting template for the MCOs, with the understanding that it would need to be updated each year to reflect the required measure set. NTC did not submit all required measures.
- The MCO must report on CMS Adult Core, Child Core, CAHPS, and HEDIS measures, as well as additional performance measures, as determined by MLTC.
- The MCO must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM

Program Description and Work Plan. This requirement was addressed within NTC's 2019 Quality Program Annual Evaluation; however, next steps are not outlined within the QI Work Plan.

HEDIS MY 2019 measures

NTC reported rates below the national Medicaid HMO averages for timeliness domain:

- COPD Spirometry Testing,
- Appropriate Treatment for URI,
- Appropriate Pharyngitis Testing,
- Breast Cancer Screening,
- Chlamydia Screening,
- Comprehensive Diabetes Care—HbA1c Measurement,
- Comprehensive Diabetes Care—Nephropathy Monitoring,
- Follow-up for ADHD Medication—Initiation,
- Timeliness of Prenatal Care,
- Postpartum Exam,
- Well-Child Visits 3–6 Years, and
- Adolescent Well-Care Visits.

Of note, the rates for Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Chlamydia Screening, Timeliness of Prenatal Care, and Well-Child Visits 3–6 Years were at or below the national Medicaid 10th percentile.

NTC reported rates below the national Medicaid HMO averages for the quality domain:

- Child/Adolescent BMI Assessment,
- Child/Adolescent Counseling for Nutrition,
- Child/Adolescent Counseling for Physical Activity,
- Human Papillomavirus Vaccine for Female Adolescents,
- Medication Management for People with Asthma (Total)—75%,
- Childhood Immunizations—Combination 2,
- Childhood Immunizations—Combination 3,
- Antidepressant Medication Management—Effective Acute Phase, and
- Antidepressant Medication Management—Effective Continuation Phase.

Of note, the rates for Child/Adolescent BMI Assessment, Child/Adolescent Counseling for Nutrition, and Child/Adolescent Counseling for Physical Activity were at or below the national Medicaid 10th percentile. The rate for Human Papillomavirus Vaccine for Female Adolescents was below the national Medicaid 5th percentile.

Q. **Corrective action (plan/provider level: 9/10/19 – 12/20/2019 for Grievance process/ operations.**

R. **Program change (system-wide level): None**

UnitedHealthcare Community Plan Review Year 2019-2020

Standards	Compliance Designation	Performance Domain
Care Management	Full Compliance	Access
Provider Network	Full Compliance	Access
Provider Services	Partial Compliance	Quality
Subcontracting	Full Compliance	Quality
Member Services and Education	Full Compliance	Quality
Quality Management	Partial Compliance	Quality
Utilization Management	Full Compliance	Quality and Timeliness
Grievances and Appeals	Full Compliance	Quality and Timeliness

The EQRO compliance review found UHCCP fully compliant in the domains of Care Management, Provider Network, Subcontracting, Grievances and Appeals, Member Services and Education and Utilization Management.

In the Access domain:
The Access domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Care Management and Provider Network.

HEDIS MY 2019 Performance
For HEDIS MY 2019, UHCCP performed **better than** the national Medicaid HMO averages for:

- Children and Adolescents' Access to Primary Care Practitioners (12–24 Months),
- Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years);
- Children and Adolescents' Access to Primary Care Practitioners (7–11 years);
- Children and Adolescents' Access to Primary Care Practitioners (12–19 years), and
- Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years).

In the Quality domain:
HEDIS MY 2019 Performance for Quality:
For HEDIS MY 2019, UHCCP performed better than the national Medicaid HMO averages for:

- Adult BMI Assessment,
- Human Papillomavirus Vaccine for Female Adolescents,
- Medication Management for People with Asthma (Total)—75%,
- Adolescent Immunization—Combo 1,
- Childhood Immunizations—Combination 2,
- Childhood Immunizations—Combination 3,

- Childhood Immunizations—Combination 10,
- Comprehensive Diabetes Care Blood Pressure < 140/90,
- Controlling High Blood Pressure,
- Use of Imaging for Low Back Pain,
- Antidepressant Medication Management—Effective Acute Phase, and
- Antidepressant Medication Management—Effective Continuation Phase.

The Timeliness domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Utilization Management, and Grievances and Appeals.

HEDIS MY 2019 Performance for timeliness:
For HEDIS MY 2019, UHCCP performed **better than** the national Medicaid HMO averages for:

- Pharmacotherapy Management of COPD—Bronchodilator,
- Breast Cancer Screening,
- Cervical Cancer Screening,
- Comprehensive Diabetes Care – Retinal Exam,
- Comprehensive Diabetes Care – HbA1c Measurement,
- Comprehensive Diabetes Care – Nephropathy Monitoring,
- Follow-up for ADHD Medication – Initiation Phase,
- Well-Child Visits (0–15 Months, 6+ Visits), and
- Adolescent Well-Care Visits.

Problems identified: **The EQRO compliance review found the following:**
The Access domain includes HEDIS MY 2019 performance and findings from two (2) of the eight (8) compliance domains: Care Management and Provider Network. UCCP reported rates **below** the national Medicaid HMO averages for: Ambulatory Care—ED Visits/1,000 MM.

IPRO reported of note that the rates for Adults' Access to Primary Care Providers (20–44 Years, 45–64 Years, and 65+ Years) were **at** the national Medicaid 95th percentile. The rate for Ambulatory Care—ED Visits/1,000 MM was **at** the national Medicaid 25th percentile.

In the domain of Quality: **Provider Services:**

- IPRO reviewed five (5) standards for Provider Services, four (4) standards were fully compliant and one (1) was partially compliant. The following details findings from the review of this partially compliant standard:
  - Nine (9) of the 10 provider complaint files demonstrated timely resolution and contained the appropriate documentation. One case took 31 days to resolve, which is outside the timeframe outlined in UHCCP's policies and procedures.

In the domain of Quality, IPRO recommends that UHCCP:

- Ensure timely resolution of provider complaints, according to UHCCP policies (which state 30 days). Provider's right to file in-person complaint should be communicated in the provider manual; and
- Develop interventions to specifically target performance for those HEDIS MY 2019 measures that are at or below the national Medicaid HMO average.

HEDIS MY 2019 Performance for Quality domain:
The MCO reported rates **below** the national Medicaid HMO averages for the following measures:

- Child/Adolescent BMI Assessment,
- Child/Adolescent Counseling for Nutrition,
- Child/Adolescent Counseling for Physical Activity, and
- Lead Screening in Children.

Of note, the rates for Childhood Immunizations—Combination 10 and Diabetes Care BP < 140/90 were **at** the national Medicaid 90th percentile. The rates for Child/Adolescent BMI Assessment and Child/Adolescent Counseling for Nutrition were **at** the national Medicaid 10th percentile.

The Timeliness domain includes HEDIS MY 2019 performance and findings from two of the eight compliance domains: Utilization Management, and Grievances and Appeals.
UCCP reported rates **below** the national Medicaid HMO averages for:

- COPD Spirometry Testing,
- Pharmacotherapy Management of COPD—Systemic Corticosteroid,
- Appropriate Treatment for URI,
- Appropriate Pharyngitis Testing,
- Chlamydia Screening,
- Follow-up for ADHD Medication—Continuation and Maintenance Phase,
- Timeliness of Prenatal Care,
- Postpartum Exam, and
- Well-Child Visits (3–6 Years).

IPRO/EQRO indicated that of note, the rates for Diabetes Care—Retinal Exam, Diabetes Care—HbA1c Measurement, and Diabetes Care—Nephropathy Monitoring were **at** the national Medicaid 90th percentile. The rates for Appropriate Treatment for URI, Appropriate Pharyngitis Testing, Chlamydia Screening, and Timeliness of Prenatal Care were **at or below** the national Medicaid 10th percentile.

MCNA Dental EQRO- Review Year 2020

Standard	Compliance Designation	Performance Domain
Care Management	N/A	Access
Provider Network	Full Compliance	Access
Provider Services	Full Compliance	Quality
Subcontracting	Full Compliance	Quality
Member Services/ Education	Full Compliance	Quality
Quality Management	Partial Compliance	Quality
Utilization Management	Full Compliance	Quality and Timeliness
Grievances/ Appeals	Full Compliance	Quality and Timeliness

The EQRO compliance review found MCNA compliant in the domain of Provider Network, Provider Services, Subcontracting, Member Services/Education, Utilization Management and Grievance and appeals. 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.

In the timeliness domain IPRO reported there were no partially compliant or non-compliant standards related to timeliness for Utilization Management, or for Grievances and Appeals. MCNA received a designation of full compliance for Utilization Management, and for Grievances and Appeals.

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

Performance Measurement

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 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.

Problems identified: The EQRO compliance review found the following:

The DBPM received a designation of partial compliance for Quality Management. MCNA received a designation of non-compliance for three elements under Quality Management:

- IPRO reviewed twenty-on (21) standards for Quality Management, thirteen (13) standards were fully compliant, three (3) were partially compliant, and three (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.

- **Corrective action (plan/provider level):** The state will review each Plan on an individual bases to determine which appropriate administrative action needs to be given. This can include a corrective action plan in the form of a written warning and monetary penalties.
- **Program change (system-wide level):** None

☒ Performance Improvement Projects [Required for MCO/PIHP]

Performance Improvement Projects - PIPs

MCNA Dental PIPs-Review Year 2020 and 2021
Preventive Dental Visit (Pdent) and Annual Dental Visits (ADV)
The DBM must conduct a minimum of one clinical and one non-clinical PIP. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.

In calendar year (CY) 2018, MCNA proposed a PIP to increase the percentage of members receiving annual dental visits. The PIP employs the modified HEDIS Annual Dental Visit

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

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 below).**

Table: 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 the Table above, 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.

The previous waiver application included a comment from MLTC that the analysis of performance indicator data would be available in the reporting year (RY) 2020 annual technical report for both of the MCNA PIPs, ADV and PDENT. The ADV final results, however, were not included.
The contract with the EQRO vendor IPRO ended and HSAG was awarded the new EQRO vendor. The decision was made by MLTC, HSAG and MCNA that the ADV measure would not be continued and therefore was not included in the 2021-2022 PIP validation report by HSAG submitted in September 2021 to MLTC. Final results for RY 2020 for the ADV measure and all intervention tracking measures were submitted by MCNA in April 2021 to MLTC and included the following final table with the RY2020 ADV results:

Table: PIP ADV Results RY 2020

Performance Indicator	**Baseline Period 01/01/2018 – 12/31/2018**	**Interim Period 01/01/2019 – 12/31/2019**	**Final Period 01/01/2020 – 12/31/2020**	**Final Goal/Target Rate**
Indicator #1: Annual Dental Visit: ages 2-20	Numerator = 86,947 Denominator = 127,545 Rate = 68.17%	Numerator = 87,283 Denominator = 127,601 Rate = 68.40%	Numerator = 80,753 Denominator = 142,099 Rate = 56.83%	Rate = 69.67%
Indicator #2: Annual Dental Visit: ages 1-20	Numerator = 88,770 Denominator = 136,779 Rate = 64.90%	Numerator = 89,265 Denominator = 136,437 Rate = 65.43%	Numerator = 82,319 Denominator = 152,414 Rate = 54.01%	Rate = 67.90%

Indicator #3 Annual Dental Visit: ≥21 years of age	Numerator = 26,743 Denominator = 62,777 Rate = 42.60%	Numerator = 26,266 Denominator = 62,737 Rate = 41.87%	Numerator = 24,521 Denominator = 72,041 Rate = 34.04%	Rate = 44.1%

PIP: Preventive Dental Service:

In calendar year (CY) 2018, MCNA also proposed a PIP to address members receiving preventive dental care at least twice per year. The PIP employs two (2) performance indicators: percentage of members who received at least one (1) preventive dental service during the measurement year (two age strata: 1–20 years and 21+ years), and percentage of members who received at least two (2) preventive dental services 6 months apart during the measurement year (age strata: 1–20 years and 21+ years).

The 2021-2022 Performance Improvement Projects Report for MCNA conducted by HSAG provided the following information below concerning the PDENT PIP.

The PIP topic addresses access to and timeliness of preventive dental care. The topic is based on the CMS 416 *Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20 (PDENT)* measure, and the topic selection was supported by analyses of historical data. The targeted population is MCNA members.

PIP Title	**Performance Indicator**
Preventive Dental Visit	1. Percent of members 1–20 years of age who received at least one preventive dental service during the measurement year.
	2. Percent of members 21 years of age or older who received at least one preventive dental service during the measurement year.
	3. Percent of members 1–20 years of age who received at least two preventive dental services six months apart during the measurement year.

	4. Percent of members 21 years of age or older who received at least two preventive dental services six months apart during the measurement year.

The table below outlines the performance indicator for the PIP.

Validation Findings

HSAG's validation evaluated the technical methods of the PIP (i.e., the PIP design). Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 2-1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status.

MCNA submitted one PIP for the 2021–22 validation cycle. The PIP received an overall *Met* validation status for both the initial submission and resubmission. The table below illustrates the validation scores.

PIP Title	Type of Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Preventive Dental Service	Initial Submission	86%	100%	*Met*
	Resubmission	90%	100%	*Met*

The table below displays the validation results for MCNA's PIP evaluated during 2021. This table illustrates MCNA's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in the table below show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps completed.

Table: Performance Improvement Project Validation Results for MCNA

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*

Design	1.	Review the Selected PIP Topic	100% (2/2)	0% (0/2)	0% (0/2)
	2.	Review the PIP Aim Statement(s)	100% (1/1)	0% (0/1)	0% (0/1)
	3.	Review the Identified PIP Population	100% (1/1)	0% (0/1)	0% (0/1)
	4.	Review the Sampling Method	*Not Applicable*		
	5.	Review the Selected Performance Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	6.	Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	7.	Review Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	8.	Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes*	9.	Assess the likelihood that Significant and Sustained Improvement Occurred	33% (1/3)	33% (1/3)	33% (1/3)
Outcomes Total			**33% (1/3)**	**33% (1/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (19/21)**		

Overall, 90 percent of all applicable evaluation elements received a score of *Met*. The following subsections highlight HSAG's findings associated with the Design, Implementation, and Outcomes stages.

Design

MCNA met 100 percent of the requirements in the Design stage, steps 1 through 6. MCNA selected a topic based on data analysis showing an opportunity for improvement. The goal of the project is to improve health outcomes for the targeted members served. MCNA's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. MCNA clearly defined the eligible population and performance indicators. MCNA's data collection process was also found to be methodologically sound.

Implementation

MCNA accurately analyzed and reported its baseline and remeasurement data for the performance indicators and statistical testing results comparing remeasurement results to baseline performance. MCNA conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Outcomes

The PIP progressed to evaluating results for the second annual remeasurement, or final measurement, during this validation cycle. Three of the four performance indicators demonstrated statistically significant improvement over baseline performance at the first remeasurement; however, these three indicators did not demonstrate sustained improvement over baseline at the second remeasurement. MCNA reported that the performance indicator results were impacted by the coronavirus disease 2019 (COVID-19) pandemic during the second remeasurement.

Analysis of Results

The table below displays data for MCNA's *Preventive Dental Visit* PIP.

Table: Performance Improvement Project Outcomes for MCNA

Performance Indicator	Baseline Period 01/01/2018 – 12/31/2018	Remeasurement 1 01/01/2019 – 12/31/2019	Remeasurement 2 01/01/2020 – 12/31/2020	Sustained Improvement
Indicator #1 Percent of members 1-20 years of age who received at least one preventive dental service during the measurement year.	**Numerator = 99,301 Denominator = 181,771** **Rate = 54.63%**	**Numerator = 99,591 Denominator =180,131** **Rate = 55.29%**	**Numerator = 87,040 Denominator = 180,829** **Rate = 48.13%**	**Not Achieved**
Indicator #2 Percent of members 21 years of age or older who received at least one preventive dental service during the measurement year.	**Numerator = 19,736 Denominator = 93,929** **Rate = 21.01%**	**Numerator = 19,281 Denominator = 93,185** **Rate = 20.69%**	**Numerator = 20,103 Denominator = 95,277** **Rate = 21.10%**	***Not Assessed***

Indicator #3 **Percent of members 1-20 years of age who received at least two preventive dental services six months apart during the measurement year.**	**Numerator = 37,089** **Denominator = 136,779** **Rate = 27.12%**	**Numerator = 38,819** **Denominator = 136,437** **Rate = 28.45%**	**Numerator = 27464** **Denominator = 152,414** **Rate = 18.02%**	**Not Achieved**
Indicator #4 **Percent of members 21 years of age or older who received at least two preventive dental services six months apart during the measurement year.**	**Numerator = 5,282** **Denominator = 62,777** **Rate = 8.41%**	**Numerator = 5,745** **Denominator = 62,737** **Rate = 9.16%**	**Numerator = 3,897** **Denominator = 72,041** **Rate = 5.41%**	**Not Achieved**

For the baseline measurement period (calendar year 2018), MCNA reported that 54.63 percent of members 1 to 20 years of age and 21.01 percent of members 21 years of age or older received at least one preventive dental service during the measurement year. MCNA's reported baseline percentages for members who received at least two preventive dental services six months apart during the measurement year were 27.12 percent for members 1 to 20 years of age and 8.41 percent for members 21 years of age and older.

For the first remeasurement period (calendar year 2019), MCNA reported a statistically significant increase over baseline results for performance indicators 1, 3, and 4. For Indicator 1, the DBM reported an increase of 0.66 percentage point in the percentage of members 1 to 20 years of age who received at least one preventive service in the measurement year, from 54.63 percent to 55.29 percent ($p < 0.0001$). For Indicator 3, the DBM reported an increase of 1.33 percentage points in the percentage of members 1 to 20 years of age who received at least two preventive services at least six months apart, from 27.12 percent to 28.45 percent ($p < 0.0001$). For Indicator 4, the DBM reported an increase of 0.75 percentage point in the percentage of members 21 years of age and older who received at least two preventive services at least six months apart, from 8.41 percent to 9.16 percent ($p < 0.0001$). The only decline in performance reported by MCNA for the first remeasurement was the decrease in the percentage of members 21 years of age and older who received at least one preventive service (Study Indicator 2), which fell 0.32 percentage point, from 21.01 percent to 20.69 percent.

For the second remeasurement period (calendar year 2020), MCNA reported declines in performance for performance indicators 1, 3, and 4; the DBM noted that the COVID-19 pandemic had impacted dental utilization rates during this measurement period. For Indicator 1, the DBM reported that 48.13 percent of members 1 to 20 years of age received at least one preventive dental service in the

measurement year, a decrease of 6.5 percentage points from baseline and a decrease of 7.16 percentage points from the first remeasurement. For Indicator 3, the DBM reported that 18.02 percent of members 1 to 20 years of age received at least two preventive services at least six months apart, a decrease of 9.1 percentage points from baseline and a decrease of 10.43 percentage points from the first remeasurement. For Indicator 4, the DBM reported that 5.41 percent of members 21 years of age and older received at least two preventive services at least six months apart, a decrease of 3.00 percentage points from baseline and a decrease of 3.75 percentage points from the first remeasurement. MCNA did report an improvement in performance at the second remeasurement for Study Indicator 2, the percentage of members 21 years of age and older who received at least one preventive service, which increased to 21.10 percent, an improvement of 0.09 percentage point over baseline and an improvement of 0.41 percentage point over the first remeasurement results. The improvement from baseline to the second remeasurement demonstrated by Performance Indicator 2 was not statistically significant ($p = 0.6391$).

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. MCNA's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

For the *Preventive Dental Visit* PIP, MCNA used brainstorming, provider feedback, and member feedback to identify the following barriers to improving performance indicator outcomes:

- Members wait until they are in pain before seeking dental care rather than scheduling routine preventive dental care.
- Lack of member knowledge of the importance of preventive dental care.
- Language and cultural barriers to seeking preventive dental care.
- Dental providers do not take the opportunity to provide preventive care when a member attends a dental treatment appointment.
- Lack of integration and coordination between physical health care providers and dental care providers.

To address the identified barriers, MCNA implemented the following interventions:

- Text message reminders, sent in the member's primary language, targeted toward members who have not received a dental service in the previous six months or who are due to schedule their second visit in the next six months.

Member service representatives conduct targeted telephone outreach to members identified as being due for preventive dental services through automated care gap alerts. The telephone outreach includes assistance in identifying a dental provider who speaks the member's preferred language and three-way calling to schedule an appointment during the outreach call.

- Mailed and text reminders to parents of members turning 1 year of age to schedule a 1-year-old check-up for their child.
- Increased provider payment for fluoride services.

• DentalLink training program offered to select high-volume primary care providers to promote referral of high-risk members for preventive dental services.

Conclusions
For this year's validation cycle, MCNA submitted a PIP focused on increasing the percentage of members who receive annual and semiannual preventive dental services. HSAG's PIP validation findings suggest that MCNA completed a thorough application of the PIP Design stage (steps 1 through 6). A sound design created the foundation for MCNA to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. In the Implementation stage (steps 7 and 8), MCNA progressed to reporting performance indicator results from the second (final) remeasurement period and carried out interventions to address identified barriers to improvement. The DBM accurately reported performance indicator data for each measurement period and statistical testing results comparing remeasurement performance to baseline performance. Although three of the four performance indicators demonstrated statistically significant improvement over baseline performance at the first remeasurement, the demonstrated improvement was not sustained for the final remeasurement period. MCNA should revisit intervention evaluation results and causal/barrier analyses, using data to direct future improvement strategies, to support further improvement in the access to and timeliness of preventive dental care for its members.

Recommendations
Based on the PIP validation findings, HSAG recommends the following for MCNA:
• Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.
• Revisit causal//barrier analyses at least annually to ensure the identified barriers and opportunities for improvement are still applicable.
• Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.

UnitedHealthcare Community Plan- PIPs

UnitedHealthcare Community Plan completed the three mandated PIP's in 2019 which were:

2) Emergency Department Follow-Up for patients with Mental Illness (FUM) and Alcohol or Other Drug Dependence (FUA).
3) Tdap in Pregnancy.

4) Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

1) Strategy: Emergency Department Follow-Up for patients with Mental Illness (FUM) and Alcohol or Other Drug Dependence (FUA)

S. Confirmation it was conducted as described:

☒ Yes
☐ No. Please explain:

- Proposed Strategy: Emergency Department Follow-Up for patients with Mental Illness (FUM) and Alcohol or Other Drug Dependence (FUA)

The rational for this PIP:

- Patients with mental health and substance use disorders are vulnerable to loosing contact with the healthcare system,
- Use of care through the Emergency Department (ED) may be a signal of crisis for individuals, and
- Use of the ED for mental health and substance use disorders may indicate lack of access to behavioral health care or primary care for these individuals.

Goals of this PIP:

- To facilitate outpatient follow up treatment for patients 6 years of age and older within a designated time period of discharge from an emergency department with a primary diagnosis of mental health illness (FUM).
- Designated time periods: a) 7 days, and b) 30 days.
- To facilitate outpatient follow up treatment for patients 13 years of age and older within a designated time period of discharge from an emergency department with a primary **diagnosis** of AOD (FUA).
- Designated time periods 13-17 years of age: a) 7 days, and c) 30 days.
- Designated time periods 13-17 years of age: b) 7 days, and d) 30 days.

The Plan used the following performance indicators:

T. **Measure 1: HEDIS® 2017 measure FUM – Follow-Up after Emergency Department Visit for Mental Illness**
U. **Measure 2: HEDIS® 2017 measure FUA – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (AOD) / Substance Use Disorder (SUD).**

Interventions were developed to address the following identified barriers for members:

- Non-compliance with follow-up visits 2020:

- **Behavior Health members who used telehealth services for follow-up visits. FUA 7 day.**
- **Behavior Health members who used telehealth services for follow-up visits. FUA 30 day**
- **Behavior Health members who used telehealth services for follow-up visits. FUM 7 day.**
- **Behavior Health members who used telehealth services for follow-up visits. FUM 30 day.**

- Social determinants of health including:
  - Transportation
  - Housing
  - Community support
  - Phone access
- Adherence to prescribed medication.

Interventions developed to address the identified barriers:

V. **Care Management member outreach and support for post-ED follow-up visits within 1 to 7 days.**
W. **Care Management member outreach and support for post-ED follow-up visits within 8 to 30 days.**
X. **Care Management member outreach for community support when event identified.**
Y. **Verification of medication refill.**

UHCCP Projects indicator:

The ED visits PIP has been extended for one year.

UCCP Performance Indicator	**Baseline Period** 2017 01/01/2017 to 12/31/2017	**Interim Period** 2018 01/01/2018 to 12/31/2018	**Interim Period** 2019* 01/01/2019 to 12/31/2019	**Final Period** 2020** 01/01/2020 to 12/31/2020	**Final Goal/Target Rate**
Indicator 1a: FUM 7 day follow-up	Num: 284 Den: 529 Rate: 53.69%	Num: 280 Den: 565 Rate: 49.56%	Num: 245 Den: 541 Rate: 45.29%	Num: 227 Den: 500 Rate: 45.40%	80%
Indicator 1b: FUM 30 day follow-up	Num: 389 Den: 529 Rate: 73.54%	Num: 390 Den: 565 Rate: 69.03%	Num: 360 Den: 541 Rate: 66.54%	Num: 330 Den: 500 Rate: 66.00%	85%
Indicator 2a: FUA 7 day follow-up (age 13-17)	Num: 2 Den: 25 Rate: 8.00%	Num: 2 Den: 23 Rate: 8.70%	Num: 3 Den: 29 Rate: 10.34%	Num: 1 Den: 33 Rate: 3.03%	30.4%

Indicator 2b: FUA 7 day follow-up (age 18+)	Num: 17 Den: 167 Rate: 10.18%	Num: 16 Den: 165 Rate: 9.70%	Num: 16 Den: 175 Rate: 9.14%	Num: 23 Den: 256 Rate: 8.98%	33.2%
Indicator 2c: FUA 30 day follow-up (age 13-17)	Num: 3 Den: 25 Rate: 12.00%	Num: 3 Den: 23 Rate: 13.04%	Num: 5 Den: 29 Rate: 17.24%	Num: 1 Den: 33 Rate: 3.03%	30.4%
Indicator 2d: FUA 30 day follow-up (age 18+)	Num: 25 Den: 167 Rate: 14.97%	Num: 23 Den: 165 Rate: 13.94%	Num: 28 Den: 175 Rate: 16.00%	Num: 35 Den: 256 Rate: 13.67%	33.2%

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

2) Proposed Strategy: Improving Immunization Rates for Tdap during Pregnancy.

The rational for this PIP:
To reduce the risk of pertussis in new mothers and their young babies, the CDC recommends that pregnant women receive a Tdap vaccine during each pregnancy. The recommended time to get the shot is the 27th through the 36th week of pregnancy, preferably during the earlier part of this time period. In rural areas of the State access to this vaccination can be limited.

Goals of this PIP:
- Receipt of Tdap at any point during pregnancy.
- Receipt of Tdap during the optimal 27-36 week gestational age period.

The Plan will use the following performance indicators:
Z. Measure 1: HEDIS® Delivery Value Set less the Non-live Births Value Set
AA. Measure 2: HEDIS® Deliver Value Set less the Non-live Births Value Set

Interventions were developed to address the following identified barriers for members:
- Personal, cultural, geographical resistance or social anti-immunization issues.
- Member non-compliance with prenatal visits.

Interventions were developed to address the following identified barriers for providers:
- Provider lack of knowledge regarding benefit of Tdap immunization during pregnancy

Interventions developed to address the identified barriers:
- Increase pregnant member education and awareness on Tdap immunization during pregnancy.

- Pregnant member outreach through Healthy First Steps (HFS) Coordinator for education on prenatal visits.
- Maternal-Child Health Coordinator and Clinical Practice Consultants outreach to OB clinics & offices to asses gaps / opportunities to address education for providers on Tdap immunization.

UCCP Project Indicators

The Tdap PIP has been extended for one year:

Performance Indicator	**MLTC Benchmark CY 2016**	**MLTC Benchmark CY 2017**	**UCCP Baseline Period CY 2017**	**UCCP Interim Period 2018**	**UCCP Interim Period 2019**	**UCCP Final Period 2020**	**UCCP Final Goal/Target Rate**
Indicator 1: Receipt of Tdap during pregnancy with continuous enrollment	Rate: 60.8%	Rate: 59.9%	Rate: 63.1%	Rate: 63.19%	Rate: 65.90%	Rate:61.43%	Rate: 85%
Indicator 2: Receipt of Tdap during the optimal 27-36 week gestational age period with continuous enrollment	Rate: 49.5%	Rate: 49.5%	Rate: 56.05%	Rate: 55.96%	Rate: 60.78%	Rate:54.01%	Rate: 75%

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

Proposed Strategy: Initiation of 17-Hydroxyprogesterone (17P) in Pregnant Women with a History of Spontaneous Preterm Birth. The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market

The rational for this PIP:
Women who have had a preterm delivery are at especially high risk for preterm delivery in a subsequent pregnancy. Research has shown weekly injections of 17P resulted in a substantial reduction in the rate of recurrent preterm delivery among women who were at particularly high risk for preterm delivery and reduced the likelihood of several complications in their infants.

Goals of this PIP:

- 17P administration during pregnancy with women with preterm birth with Continuous Enrollment in Medicaid.

The Plan will use the following performance indicators:

BB. Measure 1: Number of pregnant women as defined by HEDIS® Live Birth Value Set with history of previous premature birth as defined by the ICD-10 codes and as defined by data source.

Interventions were developed to address the following identified barriers for members:

CC. Social determinants - transportation, late enrollments

DD. Non-compliance with prenatal visits

Interventions were developed to address the following identified barriers for providers:

- Knowledge deficit regarding the billing of 17P medication.

Interventions were developed to address the following identified barriers for the Plan:

- Difficulty identifying women with history of preterm birth

Interventions developed to address the identified barriers:

- Identify pregnant members with additional social determinants or community needs.
- Healthy First Steps Outreach to pregnant members to increase prenatal visit compliance.
- Improve Provider knowledge deficit regarding the billing of 17P medication
- Promotion of use & Education of ONAF Form to clinics and providers

UHCCP PIP Outcome

As demonstrated in the table below, baseline data from CY 2017 demonstrated that just over one-fourth (25.46%) of UHCCP's eligible population had 17P initiated between the 16th and 26th week of gestation. The final measurement rate (CY 2019) data showed a decrease from baseline in the rate of pregnant members who received 17P from 25.46% to 14.07%. The goal for the PIP was to increase this rate to 35.00%. The MCO did not meet this goal by the end of the

PIP due, in part, to the Food and Drug Administration Bone, Reproductive and Urologic Drugs Advisory Committee voting in 2020 in favor of removing Makena from the market.

Initiation of 17-Hydroxyprogesterone in Pregnant Women PIP

Indicator	Baseline Rate (CY 2017)	Interim Rate Year 1 (CY 2018)	Final Rate (CY 2019)	Goal
17P initiated between the 16th and 26th week of gestation (continuous enrollment)	25.46%	24.80%	14.07%	35.00%

PIP: performance improvement project; CY: calendar year.

Due to the removal of 17p from the market, the 17P initiation PIP was discontinued in 2020. UHCCP will continue to identify members who are at risk for preterm deliveries and respond with case management outreach, 17p monitoring, and recognizing practice trends.

4) Proposed Strategy: Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

The rational for this PIP:
Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia, schizoaffective disorder or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Diabetes screening presents an opportunity to identify UnitedHealthcare Community Plan (UHCCP) Nebraska Medicaid enrollees with schizophrenia, schizoaffective disorder or bipolar disorder on antipsychotic medications (a significant at-risk population), and thus reduce medically induced diabetes through intervention.

Goals of this PIP:
Indicator 1:
The percentage of members aged 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year**.**
Indicator 2:
The percentage of members aged 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who are newly prescribed an antipsychotic medication and were screened for diabetes within 2-4 months following initial dispensing event.

Barriers:

Interventions developed:

In calendar year 2020 (CY 2020) the population being reviewed will be all eligible members who meet the 2021 SSD HEDIS® criteria. The interventions will consist of:

a) Provider education,
b) Member education
c) Care Management assistance

Project indicators/Chart:

Indicators	Interim 2020* (01/01/2020 to 12/31/2020)				Final 2021 (01/01/2021 to 12/31/2021)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Indicator 1: The percentage of members aged 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	N/A	N: 416 D: 757 R: 54.95 %	N: 610 D: 891 R: 68.46 %	N: 1,225 D: 1,506 R: 81.34 %	N: D: R:	N: D: R:	N: D: R:	N: D: R:

- Indicator 1: During 2020, 1,506 members were identified. 1,225 members received their diabetic screening during the measurement year at a rate of 81.34%.
- Indicator 2: Per communication with NCQA in Quarter 4, 2020, there were reporting components within Indicator 2 that were considered outside the NCQA Allowable Adjustment Rules and required the discontinuation of this indicator – Indicator 2 was discontinued.

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

Nebraska Total Care-PIPs

Nebraska Total Care completed the three mandated PIP's in 2019 and one PIP started in 2020

1) **17-OH Progesterone in Eligible Pregnant Women (17P) – The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market.**
2) **Follow Up Visit after ED for Mental Health or Alcohol/Substance Use Disorder (7days /30 days)**

3) Tdap during Pregnancy Performance Improvement Project
4) Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

EE. Strategy: **Reducing Avoidable Emergency Department (ED) Utilization**
FF. Confirmation it was conducted as described:

☒ Yes
☐ No. Please explain:

1) Proposed Strategy: 17-OH Progesterone in Eligible Pregnant Women
Nebraska Total Care completed the three mandated PIP's in 2019 which were:

- **The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market**

The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market:

NTC Performance Indicator	MLTC Benchmark CY 2016	MLTC Benchmark CY 2017	NTC Baseline Period CY 2017	NTC Interim Period CY 2018	NTC Final Period CY 2019	NTC Final Goal/Target Rate
Indicator #1 17-P initiated between the 16th and 26th week of gestation (continuous enrollment)	Rate: 16.4%	Rate: 25.5%	Rate: 23.00%	Rate: 33.79%	MCO due date: 4/2/2020	Rate: 35%

Goals of this PIP:

To facilitate standard of care practice in the use of 17-hydroxyprogesterone in eligible pregnant women with previous preterm births with an emphasis on sources of variance in subpopulations.

Barriers:

- For the 17P PIP a barrier that each MCO has identified is the use of compounded product by the providers.
- An additional barrier that the MCOs have identified from discussions with the providers is the concern about not always knowing the eligibility status of the member during the beginning visits with the provider (retro eligibility).

Interventions:

- The first quarter initiative was the continuous enhancements with the case management team in outreaching to our at risk pregnant members.

- Provider education on 17P, ACOG and coding guidance was the initiative for second quarter.
- A provider incentive program was implemented in the end of second / beginning of third quarter. This incentive promotes early submission of the plan's notification of pregnancy (NOP) forms which is tied to data analytics and reporting on our members' who are at risk. Another part of the incentive includes payment for appropriate 17P implementation with established outcomes.

Results and Analysis:

- MLTC has performed an analysis on the 2016 data with 18.78 benchmark rate of women who are continuously enrolled who received 17P during the clinically indicated timeframe. As more claims are processed the baseline data for NTC 2017 concluded at a rate of 23.59% of pregnant women receiving 17P with a history of spontaneous preterm birth between 16th and 26th week of gestation. Based on claims processed thus far the first quarter of 2018 rate is 23%, second quarter rate is 11.62% and third quarter rate is 40%. Not all claims or cases have been processed for an accurate reportable rate at this time.

2) Proposed Strategy: Follow Up Visit after ED for Mental Health or Alcohol/Substance Use Disorder (7days /30 days)

Goals of this PIP:

- By December 2019, the MCO aims to improve the total outpatient follow up treatment visit at the 7 day and 30 day timeframe of a member who visits the emergency department visit with a primary diagnosis of a mental health illness.
- By December 2019, the MCO aims to improve the total outpatient follow up treatment visit at the 7 day and 30 day timeframe of a member who visits the emergency department visit with a primary diagnosis of alcohol or other drug dependence.

Barriers:

- Lacking daily high volume ED activity of the members who would be captured in this PIP.

Interventions:

- Interventions for this specific PIP focuses on continuous data sharing with the hospital EDs in the larger metro area first.
- Case Management addresses the social determinates barriers that maybe preventing the member from attending a follow up appointment.
- Nebraska Total Care has established connection with the Nebraska health information exchange data base, NeHII.

Results and Analysis:
Below is a table displaying the results of the MLTC data and compares the NTC data including quarter two data thus far. NTC acknowledges that our FUA rates are below the rates experienced in 2016 by the past MCOs in Nebraska. NTC has experienced an increase in the FUM rates due to assertive case management outreach. NTC is working to ensure all HEDIS data is captured to ensure the most accurate rates.

NTC Project indicator:
The ED visits PIP has been extended for one year:

Indicator NTC	MLTC Benchmark CY 2017	NTC Baseline CY 2017	Interim CY 2018	Interim CY 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Final CY 2020
Indicator 1a: 7 day follow-up (FUM total) Goal #1	N: 985 D: 3254 R: 30.3%	N: 409 D: 884 R: 46.27%	N: 387 D: 842 R: 45.96%	N: 312 D: 662 R: 47.13%	N: 74 D: 141 R:52.48%	N: 111 D: 237 R:46.84%	N: 175 D: 372 R:47.04%	N: 233 D: 483 R:48.24%	N: 593 D:1233 R:48.09%
Indicator 1b: 30 day follow-up (FUM total) Goal # 2	N: 1750 D: 3254 R: 53.8%	N: 605 D: 884 R: 68.44%	N: 542 D: 842 R: 64.37%	N: 433 D: 662 R: 65.41%	N: 91 D: 141 R:64.54%	N: 141 D: 237 R:59.49%	N: 236 D: 372 R:63.44%	N:236 D:483 R:55.19%	N: 704 D: 1233 R:57.09%
Indicator 2c: 7 day follow-up (FUA age 13-17)	N: 6 D: 89 R: 36.7%	N: 2 D: 34 R: 5.88%	N: 5 D: 47 R: 10.64%	N: 3 D: 41 R: 7.32%	N: 0 D: 7 R: 0.00%	N: 0 D: 20 R 0.00%	N: 1 D: 29 R: 3.45%	N: 1 D: 34 R: 2.94%	N: 2 D: 98 R: 2.04%
Indicator 2d: 7 day follow-up (FUA age 18+)	N: 43 D: 635 R: 6.77%	N: 19 D: 330 R: 5.76%	N: 19 D: 308 R: 6.17%	N: 21 D: 221 R: 9.5%	N: 4 D: 62 R: 6.45%	N: 11 D: 133 R: 8.27%	N: 19 D: 212 R: 8.96%	N: 25 D: 289 R: 8.65%	N: 59 D: 696 R:8.477%

Indicator 2a: 7 day follow-up (FUA Total) Goal #3	Num: 49 Den: 724 Rate: 6.77%	N: 21 D: 364 R: 5.77%	N: 24 D: 355 R: 6.7%	N: 24 D: 262 R: 9.16%	N: 4 D: 69 R: 5.80%	N: 11 D: 153 R: 7.19%	N: 20 D: 241 R: 8.3%	N: 26 D: 323 R: 8.05%	N: 61 D: 786 R: 7.76%
Indicator 2e: 30 day follow-up (FUA age 13-17)	Num: 12 Den: 89 Rate:13.48%	N: 4 D: 34 R: 11.76%	N: 6 D: 47 R: 12.77%	N: 6 D: 41 R: 14.63%	N: 0 D: 7 R: 0.00%	N: 0 D: 20 R: 0.00%	N: 1 D: 29 R: 3.45%	N: 1 D: 34 R: 2.94%	N: 2 D: 90 R: 2.22%
Indicator 2f: 30 day follow-up (FUA age 18+)	Num: 64 Den: 635 Rate: 10.50%	N: 25 D: 330 R: 7.58%	N: 28 D: 308 R: 9.09%	N: 33 D: 221 R: 14.93%	N: 9 D:62 R:14.52%	N: 17 D: 133 R:12.78%	N: 32 D: 212 R:15.09%	N: 41 D: 289 R:14.19%	N: 99 D: 696 R:14.22%
Indicator 2b: 30 day follow-up (FUA Total) Goal #4	N: 76 D: 724 R: 10.50%	N: 29 D: 364 R: 7.97%	N: 34 D: 355 R: 9.58%	N: 39 D: 262 R: 14.89%	N: 9 D: 69 R: 13.04%	N: 17 D: 153 R:11.11%	N: 33 D: 241 R:13.69%	N: 42 D: 323 R 13.00%	N: 101 D: 786 R:12.84%

3) **Proposed Strategy:** Tdap during Pregnancy Performance Improvement Project

Goals of this PIP:
Indicator 1: To increase the percent of Nebraska Total Care pregnant women, with continuous enrollment, who receive the Tdap vaccination at any time during the pregnancy by 12.19% percentage points (from 53%, NTC baseline) in order to meet the Nebraska Total Care goal of 65.19% by December 31, 2020.
Indicator 2: To increase the percentage of Nebraska Total Care pregnant women, with continuous enrollment, who receive the Tdap vaccination during the optimal gestational time frame of the pregnancy of 27-36 weeks by 13.66% from 46.32 baseline to meet the Nebraska Total Care goal of 59.98% by December 31, 2020.**Barriers:**
Knowledge Deficit: Providers (best practice, billing, coordination of care); Knowledge Deficit: Members (benefit of Tdap / when to receive).Identifying members with behavioral health issues and those that have entered into Medicaid later into their pregnancy.
Availability of the vaccine at the provider office maybe a barrier in the smaller communities.

Interventions implemented in CY 2019 and CY 2020 included:

- Interventions cited by NTC were to have Tdap education available on their website and for care coordinators and caring connections staff to reach out to pregnant members regarding Tdap immunization during member events, site visits, and calls. Member case management and educational outreach to members regarding the Tdap vaccine.
- The MCO also developed a mobile app intervention that included targeted messaging to members; however, the intervention retired in Q4 of 2019 due to termination of the PACIFY contract.
- Provider education, billing education, development of a vaccination process.
- The final report of the Tdap Vaccination in Pregnant Women PIP with results from CY 2020 will be submitted to the EQRO and MLTC in April 2021 and incorporated into next year's technical report.

Results and Analysis:
NTC pulled 2019/2020 data based on the collective definitions for the numerator and denominator. Baseline data is indicating that 53% of pregnant women with continuous eligibility received Tdap. See the table below for the current rates reflective on the various quarters. Data is based on claims submission and is updated with each quarter.

Project Indicators:
The Tdap PIP has been extended for one year:

Indicators	Baseline CY 2017	CY 2018	CY 2019	CY 2020	Q1 2021	GOAL
Indicator 1: Receipt of Tdap during pregnancy	N: 707 D: 1334 R: 53%	N: 1514 D: 2347 R: 64.51%	N: 1401 D: 2176 R: 64.38%	N: 1441 D: 2167 R: 66.50%	N: 366 D: 575 R: 63.65%	65.19%
Indicator 2: Receipt of Tdap during the optimal 27-36 week gestational age period	N: 618 D: 1334 R: 46.32%	N: 1298 D: 2347 R: 55.30%	N: 1099 D: 2176 R: 50.51%	N: 1066 D: 2167 R: 49.19%	N: 237 D: 575 R: 41.22%	59.98%

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

4) **Proposed Strategy:** Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

The rational for this PIP:
The prevalence of diabetes is 2-3 times higher in people with severe mental illness than the general population and it contributes to increased morbidity and shortened lifespan seen in this population. Through better screening and management, a positive impact on quality of life and health outcomes can be achieved with improved collaboration and education. Physical health providers should collaborate with treating psychiatrists to optimize both medical and psychiatric treatment to prevent early mortality seen in this vulnerable population. This population can be greatly impacted in quality and length of life through education and screening.

Goals of this PIP:
Implement provider, staff, and member education to increase the percent of diabetes screening tests for adults 18–64 years of age with schizophrenia or bipolar disorder, who are using antipsychotic medications from baseline (81.6%) to final measurement (87.0%) or greater by December 31, 2022.

Barriers:

Interventions developed:
- Provide annual CM staff education on the SSD HEDIS measure and clinical practice guidelines.
- Health Plan staff to outreach annually during Q4 to SSD members who have not completed diabetic screening. Outreach to include a telephonic outreach to with reminder on need to diabetic screening and additional case management assistance as needed.
- Provider (Adult PCP as defined by NCQA and the prescribing behavioral health providers – psychiatrist and BH APRN) education every 6 months using email on the SSD HEDIS measure.
- Provide a care gap letter to Providers (Adult PCP as defined by NCQA and the prescribing behavioral health providers – psychiatrist and BH APRNs) with SSD members who have not completed diabetes screening. Letter includes identified members and information related to the practice guidelines.

Project Iindicators/Chart:

Indicator	**Baseline Period** Measure period: HEDIS 2020 (CY 2019)	HEDIS 2021 / CY 2020 / Year 1				2021	
		Q1	Q2	Q3	Q4	Q1	**Target Rate[1]**
Indicator 1: The percentage of members aged 18 to 64 years diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who received an antipsychotic medication who had a diabetes screening test during the measurement year.	N: 836 D: 1020 R: 81.6%	N: 220 D: 533 R: 41.28%	N: 452 D: 806 R: 56.08%	N: 693 D: 981 R: 70.64%	N: 866 D: 1095 R: 79.09% (Note: 114 new members to the denominator from Q3 to Q4)	N: 282 D: 671 R: 42.03%	Rate: 87%

Results and Analysis:

- Problems identified: **The COVID 19 pandemic certainly shifted the face of healthcare. COVID 19 was a probable root cause for the lower success in getting member screenings.**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

WellCare/Healthy Blue- PIPs

WellCare/Healthy Blue continued two of the three mandated PIP's from 2017 discontinued one of the PIPs in 2019 and started a new PIP in 2020:

1) **Following-up after emergency room visit with a diagnosis of mental health illness or substance use disorder.**

2) **Tdap in Pregnancy**
3) **Initiation of 17-Hydroxyprogesterone in Pregnant Women with a History of spontaneous Preterm Birth – The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market.**
4) **Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.**

GG. Strategy: **Following-up after emergency room visit with a diagnosis of mental health illness or substance use disorder.**

HH. Confirmation it was conducted as described:

☒ Yes
☐ No. Please explain:

1) **Proposed Strategy: Following-up after emergency room visit with a diagnosis of mental health illness or substance use disorder (SUD).**

The rational for this PIP:

- Patients with mental health and substance use disorders are highly prevalent this must be addressed.
- Use of care through the Emergency Department (ED) may be a signal of crisis for individuals.
- Use of the ED for mental health and substance use disorders may indicate lack of access to behavioral health care or primary care for these individuals.

Goals of this PIP:

To facilitate outpatient follow up treatment for patients to increase the rate of follow-up care provided within 7 and 30-day timeframes after an ED visits for SUD or mental illness through a variety of methods. Those methods include improving data streams to identify target populations, provider and member education, identification and use of community resources, and promoting the use of WellCare's 24/7 Crisis Line.

- Baseline to interim measurement goal: Increase the percent of members with a follow-up visit within 7 days of an ED visit for MHI from 34.51% to 37.16% by the end of 2018.
- Baseline to final measurement goal: Increase the percent of members with a follow-up visit within 7 days of an ED visit for MHI from 34.51% to 41.82% by the end of 2019.
  Designated time periods: a) 7 days, and b) 30 days.
- Increase the percent of members with a follow-up visit within 7 days of an ED visit for SUD from 4.35% to 10.35% by the end of 2018.
- Baseline to final measurement goal: Increase the percent of members with a

follow-up visit within 7 days of an ED visit for SUD from 4.35% to 16.35% by the end of 2019

- Designated time periods 13-17 years of age: b) 7 days, and d) 30 days.

The Plan will use the following performance indicators:

II. Measure 1: HEDIS® 2017 measure FUM – Follow-Up after Emergency Department Visit for Mental Illness.

JJ. Measure 2: HEDIS® 2017 measure FUA – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (AOD) / Substance Use Disorder (SUD).

Interventions were developed to address the following identified barriers for members:

- Non-compliance with follow-up visits.
- Social determinants of health including:
- Timely Identification of ED visits for SUD and mental illness.
- Lack of community resource integration with physical and behavioral providers and utilization by members.
- Need for additional after-hours, telephonic, and ED diversion support.
- Provider awareness of ED utilizing members and WellCare`s resources.
- Member awareness of and compliance with recommended ED Follow-up Guidelines.
- Adherence to prescribed medication.

Interventions developed to address the identified barriers:

KK. Care Management member outreach and support for post-ED follow-up visits within 1 to 7 days.

LL. Care Management member outreach and support for post-ED follow-up visits within 8 to 30 days.

MM. Care Management member outreach for community support when event identified.

NN. Verification of medication refill.

Project Indicators:

The ED visits PIP has been extended for one year:

Indicator HBN/WHP	Baseline Rate	Interim Rate Year 1 (CY 2018)	Interim Rate Year 2 (CY 2019)	Target Goal
Indicator 1a (FUM, 7-day follow-up)	41.07%	39.81%	25.66%	40.52%
Indicator 1b (FUM, 30-day follow-up)	63.17%	56.71%	63.82%	65.32%

Indicator 2a (FUA, 7-day follow-up, 13–17 years of age)	6.67%	3.13%	13.00%	14.50%
Indicator 2b (FUA, 7-day follow-up, 18+ years of age)	5.59%	6.12%	13.66%	15.16%
Indicator 2c (FUA, 30-day follow-up, 13–17 years of age)	17.24%	6.25%	17.94%	18.42%
Indicator 2d (FUA, 30-day follow-up, 18+ years of age)	10.60%	18.09%	18.03%	19.53%

Specifications

This measure is a first year measure for Healthcare Effectiveness Data Information Set (HEDIS® 2017) 2017 based on the 2017 National Committee for Quality Assurance (NCQA) HEDIS.

Results and Analysis:

2) Proposed Strategy: Improving Immunization Rates for Tdap during Pregnancy.

The rational for this PIP:
To reduce the risk of pertussis in new mothers and their young babies, the CDC recommends that pregnant women receive a Tdap vaccine during each pregnancy. The recommended time to get the shot is the 27th through the 36th week of pregnancy, preferably during the earlier part of this time period. In rural areas of the State access to this vaccination can be limited.

Goals of this PIP:

- Receipt of Tdap at any point during pregnancy.
- Receipt of Tdap during the optimal 27-36 week gestational age period.

The Plan will use the following performance indicators:

OO. Measure 1: HEDIS® Delivery Value Set Value Set.
PP. Measure 2: HEDIS® Deliver Value Set less the Non-live Births Value Set.

Interventions were developed to address the following identified barriers for members:

- Personal, cultural, geographical resistance or social anti-immunization issues.
- Member non-compliance with prenatal visits.

Interventions were developed to address the following identified barriers for providers:

- Provider lack of knowledge regarding benefit of Tdap immunization during pregnancy.

Performance indicators:
The Tdap PIP has been extended for one year:

Performance Indicator	**Baseline Period** 1/1/2017-12/31/2017	**First Interim Period** 1/1/2018-12/31/2018	**Second Interim Period** 1/1/2019 – 12/31/2019	**Final Period 1/1/2020 - 12/31/2020**	**Goal Met (Y/N)**
Indicator #1 Increase the overall rate of administration of Tdap in pregnant women	Num = 1595 Denom = 2481 Rate = 64.3%	Num = 2058 Denom = 3191 Rate = 64.5%	Num = 2133 Denom = 3188 Rate = 67.0%	Num = 1640 Denom = 2457 Rate = 66.7%	Goal: 79.9% N

Indicator #1 with **NESIIS** Tdap Immunization data	*New for 2019 Interim Report	*New for 2019 Interim Report	Num = 2264 Denom = 3188 Rate = 71.1%	Num=1665 Denom= 2457 Rate= 67.8%	Goal: 79.9% N
Indicator #2 Increase the rate of administration of Tdap during the specified timeframe of 27 to 36 weeks of gestation	Num = 1412 Denom = 2481 Rate = 56.9%	Num = 1852 Denom = 3191 Rate = 58.04%	Num = 1947 Denom = 3188 Rate = 61.1%	Num = 1476 Denom = 2457 Rate = 60.1%	Goal: 69.9% N
Indicator #2 with **NESIIS** Tdap Immunization data	*New for 2019 Interim Report	*New for 2019 Interim Report	Numerator = 2133 Denominator = 3188 Rate = 67.0%	Num= 1484 Denom= 2457 Rate: 60.3%	Goal: 69.9% N

3) Proposed Strategy: Initiation of 17-Hydroxyprogesterone (17P) in Pregnant Women with a History of Spontaneous Preterm Birth – The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market.

The rational for this PIP:
Women who have had a preterm delivery are at especially high risk for preterm delivery in a subsequent pregnancy. Research has shown weekly injections of 17P resulted in a substantial reduction in the rate of recurrent preterm delivery among women who were at particularly high risk for preterm delivery and reduced the likelihood of several complications in their infants.

Goals of this PIP:
17P administration during pregnancy with women with preterm birth with Continuous Enrollment in Medicaid.

The Plan will use the following performance indicators:

- Measure 1: Number of pregnant women as defined by HEDIS® Live Birth Value Set with history of previous premature birth as defined by the ICD-10 codes and as defined by data source.

Interventions were developed to address the following identified barriers for members:

- Social determinants - transportation, late enrollments.
- Non-compliance with prenatal visits.

Interventions were developed to address the following identified barriers for providers:

- Knowledge deficit regarding the billing of 17P medication.

Interventions were developed to address the following identified barriers for the Plan:

- Difficulty identifying women with history of preterm birth.

Interventions developed to address the identified barriers:

- Identify pregnant members with additional social determinants or community needs.
- Healthy First Steps Outreach to pregnant members to increase prenatal visit compliance.
- Improve Provider knowledge deficit regarding the billing of 17P medication.
- Promotion of use & Education of ONAF Form to clinics and providers.

Project Indicators

The 17P PIP was discontinued December 31, 2019 due to the removal of Makena® from the market:

Performance Indicator	MLTC Benchmark CY 2016	MLTC Benchmark CY 2017	WHP Baseline Period CY 2017	WHP Interim Period CY 2018	WHP Final Period CY 2019	WHP Final Goal/Target Rate
Indicator #1 17-P initiated between the 16th and 26th week of gestation (continuous enrollment)	Rate:16.4%	Rate: 25.25%	Rate:29.71%	Rate: 22.2%	MCO due date: 4/2/2020	Rate: 36.6%

Results and Analysis:

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

Wellcare/HealthyBlue PIP Outcome

As demonstrated in the table below, baseline data were collected for CY 2017 and demonstrated that less than one-third (29.7%) of women with a previous spontaneous preterm birth initiated 17P. Data from CY 2018 demonstrated a decline in the percentage of pregnant members with a history of preterm birth who received 17P to 22.2%. In the final year of the project, CY 2019, performance increased to 29.0% from the interim MY. By the end of the PIP, the goal of 36.6% was not achieved due to providers changing their practice based on the PROLONG clinical trial results.

Proportion of Healthy Blue Members in Eligible Population who Received 17P PIP

Indicator	Baseline Rate	Interim Rate Year 1 (CY 2018)	Final Rate (CY 2019)	Target Goal

	(CY 2017)			
Healthy Blue members (in the eligible population) who received 17P	29.7%	22.2%	29.0%	36.6%

17P: 17-hydroxyprogesterone; PIP: performance improvement project; CY: calendar year.

The 17P PIP was discontinued in 2020 due to the removal of Makena from the market. The final report was submitted to MLTC and IPRO in April 2020. The MCO will continue to work closely with prenatal care providers to decrease the risk of premature births despite the discontinued use of Makena.

4) **Proposed Strategy:** Diabetes Screening for Nebraska Medicaid Enrollees Diagnosed with Schizophrenia or Bipolar Disorder on Antipsychotic Medications.

The rational for this PIP:
Increasing diabetes screening rates in members with mental illness on an antipsychotic medication will help identify diabetes within this population earlier. Identification of early onset of diabetes will help to prevent secondary complications of diabetes and may decrease the cost of care.

Goals of this PIP:
Indicator 1: The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Barriers:

- Variation in diabetic screening among providers within this eligible population.
- Variation in BH care coordination and integration with primary care.
- Lack of member understanding.

Interventions developed to address identified barriers:
Offer care management services to members upon telephonic outreach to all members that were dispensed an antipsychotic without an antipsychotic dispensing event 12 months prior.
Initiate member training on SSD screening, medication compliance and member incentives for participating screens.
Outreach to the top 10 provider organizations with the most attributed eligible Members.
Provide/refer to the provider SSD educational handout and discuss current compliance rate to these organizations quarterly.
PCP offices to receive monthly reports. The gap report will identify those attributed members that are noncompliant with the SSD measure for the CY on a monthly basis.

Project indicators/Chart:

WHP/HBN Indicator	Baseline Period Measure period:	Interim Period Measure period:	Final Period Measure period:	Target Rate[1]
Indicator 1: The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**N:487 D:632 R: 77.06%**	**N: 542 D: 743 R: 72.95%**	**N: D: R:**	**Rate: 81.62%**

Results and Analysis:

- Problems identified: **None**
- Corrective action (plan/provider level): **None**
- Program change (system-wide level): **None**

Section D: Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming waiver period, called Prospective Year 1 (P1) through Prospective Year 5 (P5). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.4 and 438.5 and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officers making these assurances: **Jeremy Brunssen**

c. Telephone Number: **402-540-0380**

d. E-mail: **Jeremy.Brunssen@nebraska.gov**

e. The State is choosing to report waiver expenditures based on:
☐☒ date of payment.
☐☐ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

For Renewal Waivers Only (not conversion) – Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a. ☒ The State provides additional services under 1915(b)(3) authority.

b. ☐ The State makes enhanced payments to contractors or providers.

c. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d. ☐ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental*

PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a. ☒ MCO

The Section D template reflects Heritage Health services being provided via the MCO delivery system effective January 1, 2017.

The Adult Expansion, Heritage Health Adults (HHA) coverage via MCO delivery system, was implemented and began enrollment effective October 1, 2020. Between October 1, 2020, and September 30, 2021, the Adult Expansion program design included different benefit packages among beneficiaries.

- Beneficiaries who **did not meet** personal responsibility requirements received the "basic" benefit package. The basic benefit package excluded coverage for vision, dental and over-the-counter pharmacy services.
- Beneficiaries who **met** the personal responsibility requirements received the "prime" benefit package. The prime benefit package included to vision, dental and over-the-counter pharmacy services.
- Beneficiaries who were classified as "Medically frail," or pregnant or age 19-20, received state plan benefits, like regular Medicaid beneficiaries.
- Beginning October 1, 2021, the State eliminated the differential benefit packages. All Expansion adult beneficiaries were eligible to receive the state plan benefit package.

b. ☐ PIHP

c. ☒ PAHP

The PAHP is a Dental Benefits Manager that administers Medicaid's dental services through network development and member education. The Dental Benefits Manager began October 1, 2017.

Beginning October 1, 2020, certain Adult Expansion beneficiaries, those who were enrolled in "prime" or were "medically frail", were eligible to receive dental services while those enrolled in "basic" were not. The State modified the Adult Expansion program design effective October 1, 2021 providing all Adult expansion beneficiaries coverage for dental services. Please refer to MCO delivery system discussion above for effective dates of the changes to the HHA program.

d. ☐ Other (please explain):

PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1. ☐ First Year:
   2. ☐ Second Year:
   3. ☐ Third Year:
   4. ☐ Fourth Year:

b. ☐ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. Other reimbursement method/amount. $_____. Please explain the State's rationale for determining this method or amount.

Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a. ☐ Population in the base year data
   1. ☐ Base year data is from the same population as to be included in the waiver.
   2. ☐ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ☐ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care, (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c. ☐ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

   _____

d. ☐ [Required] Explain any other variance in eligible member months from BY to P2:

   _____

e. ☐ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f. ☐ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g. ☐ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

   _____

For Conversion or Renewal Waivers:

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

   R1 Period: July 1, 2020 – June 30, 2021
   R2 Period: July 1, 2021 – December 31, 2021 (six-month period)

   The Base Year (BY) reflected in the Appendix D templates includes R1 and six-months of R2.

The following populations will remain outside of the waiver and cost-effectiveness:

- Aliens who are eligible for Medicaid for an emergency condition only.
- Members who have excess income or who are designated to have a Premium Due and do not have continuous eligibility.
- Members with Medicare coverage where Medicaid only pays co-insurance and deductibles.
- Members residing in a Correctional Facility eligible for an emergency condition only
- Members participating in an approved DHHS PACE program

b. ☒ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

The formulas included in Appendix D1 and D5 have been updated to reflect this change. Notes are included in each Appendix where a formula has been modified.

Note: R1 reflects twelve months. R2 reflects six-months.

- *The rate of change between R2 and R1 represents the difference between six-months of R2 and twelve months R1 and is noted on Appendix D1.*
- *The rate of change between R2 and P1 represents the difference between six-months of R2 and twelve months P1 and is noted on Appendix D1.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
The increase in member months over time was associated with the following:

Medicaid Adult Expansion (MEG = EXP)
As described in prior responses, on October 1, 2020, Nebraska implemented the Heritage Health Adult (HHA) program, authorized through a section 1115 waiver. The inaugural year of the HHA program included three separate benefit packages, "Basic", "Prime" and "Medically Frail". Qualification for Basic versus Prime was based on meeting personal responsibility requirements. Medically Frail beneficiaries were determined based on clinical criteria.

In February 2021, the CMS notified Nebraska that it was beginning a process to determine whether to withdraw the states section 1115 approval. Nebraska subsequently modified its HHA program to eliminate the "Basic", "Prime", and

"Medically Frail" benefit packages and provide the state benefit package for **all** adult expansion beneficiaries effective October 1, 2021. Refer to the following table illustrating the benefit packages effective during the BY periods.

- Beneficiaries received the "basic" benefit package unless they met personal responsibility requirements (or were pregnant or aged 19-20).
- Beneficiaries received the "prime" benefit package based on meeting personal responsibility requirements. This provided prime members access to vision, dental and over-the-counter pharmacy benefits.
- Beneficiaries who were classified as "Medically frail" received state plan benefits, like regular Medicaid beneficiaries.
- Beginning October 1, 2021, the State eliminated differential benefit packages and all covered Expansion adults were eligible to receive the state plan benefit package.

BY Period	Adult Expansion (Varied Benefit Packages by Population)	Adult Expansion (State Plan Benefit Package for all Populations)
R1 (July 1, 2020 – June 30, 2021)	October 1, 2020, to June 30, 2021	n/a
R2 (July 1, 2021 – December 31, 2021)	July 1, 2021, to September 30, 2021	October 1, 2021, to December 31, 2021

COVID-19 and Public Health Emergency

The Base Year reflects the period of July 1, 2020, through December 31, 2021 and member months are influenced by the moratorium on Medicaid disenrollment.

d. ☐ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

e. ☒ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
The R1 and R2 periods are state fiscal years as outlined below:

- R1 Period: July 1, 2020 – June 30, 2021
- R2 Period: July 1, 2021 – December 31, 2021 (six-month period).

The Base Year (BY) reflected in the Appendix D templates includes R1 and six-months of R2.

Appendix D2.S – Services in Actual Waiver Cost

For Initial Waivers:

a. ☐ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a. ☒ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

The covered services for Adult Expansion changed during the BY periods. Please see the explanation of the changes in the response to "c." above.

Projections from the BY to P1 in Appendix D5 are explained in responses to the state plan trend adjustments and program changes below.

b. ☒ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **School-Based Services and LTSS services are excluded from the Waiver for all time periods, as they are not a part of the Heritage Health program and are provided via FFS delivery under the State Plan Authority.**

Appendix D2.A – Administration in Actual Waiver Cost

☒ [Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state

the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	Appendix D5 should reflect this.		Appendix D5 should reflect this.

The allocation method for either initial or renewal waivers is explained below:

a. ☐ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b. ☒ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

The CMS 64.10 data for the Nebraska waiver reflect the approved allocation methodology for administrative expenses being allocated to the waiver program. MMIS administrative expenses are allocated to the Nebraska waiver based on the actual waiver program costs as a percentage of the total Medicaid program cost.

The administrative costs reflected on Appendix D3 are consistent with costs that are being reported on the CMS 64.10 waiver forms. Waiver administrative costs also include 100% of contract expenses solely applicable to the waiver program. For example, these include contract expenses for actuarial services.

c. ☐ Other (Please explain).

Appendix D3 – Actual Waiver Cost

a. ☒ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State-Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State-Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
1915(b)(3) – Aggregate of services inherent in the historical rate period include: • Adult Substance Use; • Treatment crisis intervention; • Crisis stabilization; • Intensive outpatient; • Psychiatric nursing services.	**BY aggregate 1915(b)(3) = $2.79 PMPM** **Aggregate PMPM is weighted on BY MM Basis. For aggregate PMPM value please refer to Appendix D5 (column T; row 20)*	**5.8% annual trend for P1 through P5**	• **$3.13 for P1 PMPM. (*This is a 24 month change between BY and P1*)** • **$3.31 in P1 to P2** • **$3.50 in P2 to P3** • **$3.70 in P3 to P4** • **$3.92 in P4 to P5** ** See Appendix D5 (column W; rows 20, 39, 58, 77, 96) for aggregate projected PMPM.*

These adjustments vary by MEG.

b. ☐ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☒ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the

stop-loss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ☐ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires **MCOs**/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. ☒ The State provides stop/loss protection (please describe): **Risk corridor protection existed in the Heritage Health program such that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year in CY17, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners under the contract. Currently the Heritage Health and DBPM programs do not have loss protection but do have MLR and profit caps. The Expansion program will have a 2% risk corridor for the initial period until Expansion claim/encounter data can be used in the development of capitation rates.**

d. ☐ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. ☐ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses.

   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2. ☐ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of**

Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses.

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint OR Conversion Waiver for DOS within DOP

Appendix D4 – Initial Waiver - Adjustments in the Projection

This is a Renewal waiver for DOP; skip to J.

Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments

If this is an Initial waiver submission, skip this section. States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method, and mathematically account for the adjustment in Appendix D5.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care

program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☒ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is:
The trend rate between the BY and P1 reflected in Appendix 5 is as follows:

MEG	Annual State Plan Trend BY to P1
ABD	10.6%
CHIP	8.1%
DUAL	1.7%
FAM	11.5%
WARD	10.7%
EXP	12.0%

The state plan trend factor reflects the rate of change between the BY period and the P1 period based on the Heritage Heath including Adult Expansion, and Dental capitation rates. Further description of the factors and the development of the P1 is described below.

Developing P1 Projections and State Plan Trend

The PHE influenced the methodology used to project the BY period to P1. P1 projections are developed using Heritage Health including Adult Expansion and Dental program capitated rates.

Inflation factors represented in Appendix D5 for P1 are based on the Heritage Health including Adult Expansion, and dental capitation rates developed for the CY2022 contract period and projected CY2023 capitation rates. The inflation factors presented in Appendix D5 represent the annualized difference between the BY and the P1 projected capitation rates, before the impact of program changes, for each Medicaid Eligibility Group (MEG).

The annual inflation factors reflected in Appendix D5 for P1 were derived by calculating the annualized difference between the projected state plan services and BY period.

COVID-19 and Public Health Emergency
The COVID-19 and PHE impacted program member months, utilization, expenditures and PMPM values during the BY period. This includes increased enrollment due to the moratorium on disenrollment and impacted utilization and service delivery.

Heritage Health Adult Expansion
Note that the difference between the BY and P1 and trend is impacted by the implementation and subsequent changes to the Adult Expansion benefit packages.

2. ☒ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate-setting regulations) *(i.e., trending from present into the future)*.

   i. ☒ State historical cost increases. Please indicate the years on which the rates are based:
   The state plan trend factor reflected in Appendix D5 for P1 reflects the annualized percentage change between the combined R1 (July 1, 2020 – June 30, 2021) and R2 (July 1, 2021, to December 31, 2021) periods and the P1 (October 1, 2022 – September 30, 2022) period. The P1 PMPM is based on the Heritage Health (HH), Heritage Health Adult (HHA), and Dental program capitation rates.

   The HH and HHA capitation rates include:
   - Current rates effective for Calendar Year (CY) 2022 (January 1, 2022, to December 31, 2022). These rates include the impact of program changes effective July 1, 2022.
   - The CY 2022 rates were projected an additional twelve months to the period of (January 1, 2023, to December 31, 2023)

   The Dental capitation rates include:
   - Current rates effective for State Fiscal Year (SFY) 2023 (July 1, 2022, to June 30, 2023).
   - The SFY 2023 rates were projected an additional twelve months to the period of (July 1, 2023, to June 30, 2024).

   Heritage Health Capitation Rate Weighting
   The capitation rates, on a PMPM basis, were segmented into the components associated with trend and prospective program changes.

These PMPMs by rate cell were aggregated into the cost-effectiveness Medicaid Eligibly Groups (MEGs) based on the projected enrollment by rate cell for the P1 projection period as outlined in the table below.

Heritage Health Capitation Rate projections used to develop P1

Rating Period	Effective Dates	P1 Weighting (Projected Member Months)
CY2022	January 1, 2022, to December 31, 2022	Three months *October 1, 2022 – December 31, 2022*
CY2023	January 1, 2023, to December 31, 2023	Nine months *January 1, 2023 – September 30, 2023*

Dental Capitation Rate Weighting

The capitation rates, on a PMPM basis, were segmented into the components associated with trend and prospective program changes. These PMPMs by rate cell were aggregated into the cost-effectiveness Medicaid Eligibly Groups (MEGs) based on the projected enrollment by rate cell for the P1 projection period as outlined in the table below.

Dental Capitation Rate projections used to develop P1

Rating Period	Effective Dates	P1 Weighting (Projected Member Months)
SFY2023	July 1, 2022, to June 30, 2023	Nine months *October 1, 2022 – June 30, 2023*
SFY2024	July 1, 2023, to June 30, 2024	Three months *July 1, 2023 – September 30, 2023*

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
.

P1 State Plan Trend Adjustment

The state plan services annual trend rate reflected for P1 is the annualized difference between the R1 and R2 period and the projected capitated rate for P1. The factor for each MEG reflects the annualized difference

between R1 and Six-months of R2 (July 1, 2020, through December 31, 2021) and accounts for:

- Actual capitated program expenditures that occurred during the period of the Public Health Emergency
- Influence of the PHE moratorium on enrollment including demographic changes on the capitation rates
- Historical program changes that occurred between July 1, 2020, and December 31, 2021.

P2 through P5 State Plan Trend Adjustment

The state plan trend adjustment for P1 to P2 and each subsequent projection year reflected in Appendix D represents the weighted average annual trend factor included in the HH, HHA and Dental capitated rate development.

MEG	P1 to P2	P2 to P3	P3 to P4	P4 to P5
ABD	10.5%	6.5%	6.5%	6.5%
CHIP	8.1%	6.3%	6.3%	6.3%
DUAL	1.7%	3.6%	3.6%	3.6%
FAM	11.6%	6.0%	6.0%	6.0%
WARD	9.3%	3.4%	3.4%	3.4%
EXP	12.5%	6.5%	6.5%	6.5%

During the five-year waiver period, the state may need to amend the cost-effectiveness trend projections for P2 through P5 to reflect unwinding the PHE.

ii. ☐ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
    i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ☒ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program. Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ☒ An adjustment was necessary and is listed and described below:
   i. ☒ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
   For each change, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ☐ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ☐ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ☐ Determine adjustment for Medicare Part D dual eligible

E. ☒ Other (please describe):

The program change adjustments are based on the HH including Adult Expansion and Dental capitation rates.

P1 Program Change Adjustment

The program change reflected for P1 is the difference between R1 and R2 period and the projected capitated rate for P1. The factor for each MEG reflects:

- Program changes implemented mid-year of CY2022 HH capitation rates including legislative appropriations for provider fee increases, inpatient hospital Diagnostic Related Grouping rebasing, and the approved University of Nebraska Medical Center average commercial rate directed payment.

P2 through P5 State Plan Trend Adjustment

The program change adjustments are zero since future program change adjustments for P2 through P5 are unknown.

During the five-year waiver period, the state may need to amend the cost-effectiveness projections for P2 through P5 to reflect unwinding the PHE or new legislative appropriations or other benefit and reimbursement changes implemented by the Medicaid agency.

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv. ☐ Changes brought about by legal action (please describe):
For each change, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ☐ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ☐ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ☐ Other (please describe):

v. ☒ Changes in legislation (please describe):

For each change, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ☐ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ☒ Determine adjustment based on currently approved SPA. PMPM size of adjustment _

The program change adjustments are based on the HH including Adult Expansion, and Dental capitation rates.

P1 Program Change Adjustment

The program change reflected for P1 is the difference between R1 and R2 period and the projected capitated rate for P1. The factor for each MEG reflects:

- Program changes implemented mid-year of CY2022 HH rates including legislative appropriations for provider fee increases, inpatient hospital Diagnostic Related Grouping rebasing, and the approved University of Nebraska Medical Center average commercial rate directed payment.

P2 through P5 State Plan Trend Adjustment

The program change adjustment is zero percent since known Program change adjustments for P2 through P5 are unknown.

During the five-year waiver period, the state may need to amend the cost-effectiveness projections for P2 through P5 to reflect new legislative appropriations, any other covered benefit or reimbursement changes implemented by the Medicaid agency and the impact of the expiration of the PHE. The impact of the expiration of the PHE will include changes to enrollment and any acuity changes that impact the capitated rates.

D. ☐ Other (please describe):

vi. ☐ Other (please describe):

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ☐ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment:

C. ☐ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ☐ Other (please describe):

vii. ☐ Other (please describe):

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. ☐ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. ☐ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ☐ Other (please describe):

c. ☒ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☒ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii. ☒ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☒ State Historical State Administrative Inflation. The actual trend rate used is:
Please document how that trend was calculated:

D. ☒ Other (please describe):

Current allocation of administrative costs is primarily contract labor. The annual trend rate of 4.7% was used to project BY administrative costs to P1 and P2-P5. The trend factor is based on the Bureau of Labor Statistics March 2022 Employment Cost Index at https://www.bls.gov/news.release/pdf/eci.pdf

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☒ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is:

5.8% overall. The trend factors vary by MEG as identified on Appendix D5**.**

Because the 1915(b)(3) services are inherent in the HH capitation rates the trend factor used to project the 1915(b)(3) services to P1 are based on the overall HH managed care capitation rate trend factors.

2. ☒ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
   i. ☒ State historical 1915(b)(3) trend rates:
      1. Please indicate the years on which the rates are based:

         The trend factors are based on the weighted average SFY2022 and SFY2023 HH capitation rates as described in the state plan service trend responses (Appendix D4.a of this pre-print).

      2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

         The trends vary by MEG and represent the weighted average SFY2022 and SFY2023 HH capitation rates as described in the state plan service trend responses (Appendix D4.a of this pre-print).

   ii. ☐ State Plan Service Trend
      1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above:

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
   1. List the State Plan trend rate by MEG from **Section D.I.J.a** above:
   2. List the Incentive trend rate by MEG if different from **Section D.I.J.a** above:
   3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population, which includes accounting for Part D dual eligibles. Please account for this adjustment in **Appendix D5**.
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. ☐ Other (please describe):

1. ☐ No adjustment was made.
2. ☒ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

All figures reported on Appendix D3 and Appendix D5 are net of Pharmacy rebates, thus no program change appears in Appendix D5 to remove rebates. Pharmacy rebates are removed from capitation rates prior to the calculation of Waiver

expenditures in the prospective period, and pharmacy rebates are removed from actual expenditures in the retrospective period.

All figures reported on Appendix D3 and Appendix D5 are net of Pharmacy rebates, thus no program change appears in Appendix D5 to remove rebates. Pharmacy rebates are removed from capitation rates prior to the calculation of Waiver expenditures in the prospective period, and pharmacy rebates are removed from actual expenditures in the retrospective period.

Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

Appendix D7 – Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
   1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**.

      The caseload, (member month), changes between the BY (R1 and R2) and P1 are associated with two significant events:
      - The moratorium on disenrollment due to the Public Health Emergency.
      - Implementation of the Adult expansion program and the enrollment ramp-up associated with the new coverage group.
   2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**.

      .

      The rate of change between BY (R1 and R2) to P1 for ABD, CHIP, Dual, Family and Wards MEGs reflects an annualized rate of change inclusive of state plan trend, program changes and impacts to the Heritage Health managed care capitated rates associated with the Public Health Emergency (COVID-19 impacts on utilization and cost and acuity associated with the moratorium on Medicaid beneficiaries' disenrollment).

P2 through P5 annualized rates of change reflect the state plan trend factors reflected in HH including Adult Expansion and dental capitation rate development.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J:**

   The rate of change between BY (R1 and R2) to P1 for ABD, CHIP, Dual, Family and Wards MEGs reflects an annualized rate of change inclusive of state plan trend, program changes and impacts to the Heritage Health managed care capitated rates associated with the Public Health Emergency (COVID-19 impacts on utilization and cost and acuity associated with the moratorium on Medicaid beneficiaries' disenrollment).

   P2 through P5 annualized rates of change reflect the state plan trend factors reflected in HH and dental capitation rate development.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-D.7

Please see attached Excel spreadsheets.
Appendix D: [2022.06.30 NE03_R9_Sec D Appendices Renewal (Deliverable)]

Attachment A

Tribal Consultation

Please see attached:
1. Copy of e-mail; *Nebraska 1915(b) Waiver, Tribal Notice* sent from the DHHS Medicaid SPA account to Tribal representatives (Attachment 1A)
2. *Tribal Cover Letter 1915(b) Waiver* (Attachment 2A)
3. *Tribal Summary 1915(b) Waiver* (Attachment 3A)

Attachment B Heritage Health Performance Measures

Adult Core Measures

AMM-AD: Antidepressant Medication Management
AMR-AD: Asthma Medication Ratio: Ages 19–64
BCS-AD: Breast Cancer Screening
CBP-AD: Controlling High Blood Pressure
CCP-AD: Contraceptive Care – Postpartum Women Ages 21–44
CCS-AD: Cervical Cancer Screening
CCW-AD: Contraceptive Care – All Women Ages 21-44
CHL-AD: Chlamydia Screening in Women Ages 21–24
COB-AD: Concurrent Use of Opioids and Benzodiazepines
FUA-AD: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 21 and Older
FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness

FVA-AD: Flu Vaccinations for Adults Ages 18 to 64
HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
HPCMI-AD: Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HBA1c) Poor Control (>9.0%)
HVL-AD: HIV Viral Load Suppression
IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
MSC-AD: Medical Assistance with Smoking and Tobacco Use Cessation
OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer
OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder
PC01-AD: PC-01: Elective Delivery
PCR-AD: Plan All-Cause Readmissions
PPC-AD: Prenatal and Postpartum Care: Postpartum Care
PQI01-AD: PQI 01: Diabetes Short-Term Complications Admission Rate
PQI05-AD: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI08-AD: PQI 08: Heart Failure Admission Rate
PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate
SAA-AD: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SSD-AD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Child Core Measures

ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication
AMB-CH: Ambulatory Care: Emergency Department (ED) Visits

AMR-CH: Asthma Medication Ratio: Ages 5–18
APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
AUD-CH: Audiological Diagnosis No Later than 3 Months of Age
CCP-CH: Contraceptive Care – Postpartum Women Ages 15–20
CCW-CH: Contraceptive Care – All Women Ages 15-20
CHL-CH: Chlamydia Screening in Women Ages 16–20
CIS-CH: Childhood Immunization Status
DEV-CH: Developmental Screening in the First Three Years of Life
FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17
IMA-CH: Immunizations for Adolescents
PPC-CH: Prenatal and Postpartum Care: Timeliness of Prenatal Care
W30-CH: Well-Child Visits in the First 30 Months of Life
WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents
WCV-CH: Child and Adolescent Well-Care Visits

HEDIS Measures

Effectiveness of Care: Prevention and Screening
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
CIS: Childhood Immunization Status
IMA: Immunizations for Adolescents
LSC: Lead Screening in Children
BCS: Breast Cancer Screening
CCS: Cervical Cancer Screening
CHL: Chlamydia Screening in Women
Effectiveness of Care: Respiratory Conditions
CWP: Appropriate Testing for Children with Pharyngitis
SPR: Use of Spirometry Testing in the Assessment and Diagnosis of COPD
PCE: Pharmacotherapy Management of COPD Exacerbation
MMA: Medication Management for People With Asthma
AMR: Asthma Medication Ratio

Effectiveness of Care: Cardiovascular Conditions
CBP: Controlling High Blood Pressure
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack
SPC: Statin Therapy for Patients With Cardiovascular Disease
CRE: Cardiac Rehabilitation
Effectiveness of Care: Diabetes
CDC: Comprehensive Diabetes Care
KED: Kidney Health Evaluation for Patients With Diabetes
SPD: Statin Therapy for Patients With Diabetes
Effectiveness of Care: Behavioral Health
AMM: Antidepressant Medication Management
ADD: Follow-Up Care for Children Prescribed ADHD Medication
FUH: Follow-Up After Hospitalization for Mental Illness
FUM: Follow-Up After Emergency Department Visit for Mental Illness
FUI: Follow-Up After High Intensity Care for Substance Use Disorder
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
POD: Pharmacotherapy for Opioid Use Disorder (POD)
SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia
SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics
Effectiveness of Care: Overuse/Appropriateness
NCS: Non-Recommended Cervical Cancer Screening in Adolescent Females
PSA: Non-Recommended PSA-Based Screening in Older Men
URI: Appropriate Treatment for Children With URI
AAB: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
LBP: Use of Imaging Studies for Low Back Pain
HDO: Use of Opioids at High Dosage
UOP: Use of Opioids From Multiple Providers
COU: Risk of Continued Opioid Use
Effectiveness of Care: Measures Collected Through the Medicare Health Outcomes Survey
FVA: Flu Vaccinations for Adults Ages 18-64
FVO: Flu Vaccinations for Adults Ages 65 and Older

MSC: Medical Assistance With Smoking and Tobacco Use Cessation
PNU: Pneumococcal Vaccination Status of Older Adults
Access/Availability of Care
AAP: Adults' Access to Preventive/Ambulatory Health Services
IET: Initiation and Engagement of AOD Abuse or Dependence Treatment
PPC: Prenatal and Postpartum Care
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Utilization
W30: Well-Child Visits in the First 30 Months of Life
WCV: Child and Adolescent Well-Care Visits
FSP: Frequency of Selected Procedures
AMB: Ambulatory Care
IPU: Inpatient Utilization--General Hospital/Acute Care
IAD: Identification of Alcohol and Other Drug Services
MPT: Mental Health Utilization
ABX: Antibiotic Utilization
Risk Adjusted Utilization
PCR: Plan All-Cause Readmissions
Measures Collected using Electronic Clinical Data Systems
BCS-E: Breast Cancer Screening
ADD-E: Follow-Up Care for Children Prescribed ADHD Medication
DSF-E: Depression Screening and Follow-Up for Adolescents and Adults
DMS-E: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
DRR-E: Depression and Remission or Response for Adolescents and Adults
ASF-E: Unhealthy Alcohol Use Screening and Follow-Up
AIS-E: Adult Immunization Status
PRS-E: Prenatal Immunization Status
PND-E: Prenatal Depression Screening and Follow-Up
PDS-E: Postpartum Depression Screening and Follow-Up

Attachment C Dental Benefits Manager Performance Measures

DBM Quality Performance Program Measures Indicated in the contract July 1, 2020-June 30, 2021:

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Calendar Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) calendar days of the date of receipt. The date of receipt is the date the MCO receives the claim.	≥ 95% within 15 calendar days	5%
Reporting timeliness: Contractually required report submissions and resubmittals, when requested by MLTC, must be submitted on or before the applicable deadline	95% submitted on or before due date	10%
Report Accuracy: Reports submitted must be accepted by MLTC pursuant to MLTC specifications.	90% accepted by MLTC	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	15%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within twenty (20) calendar days from the day the DBPM receives the appeal.	≥ 95% within 20 calendar days	15%
MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	43%	25%

Adult Annual Dental Visit The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.	25%	20%	