6-000 QUALITY

6-001 OVERALL QUALITY STRATEGY: 482 NAC 6-000 sets forth the requirements of the Nebraska Health Connection (NHC) Quality Strategy (See 480-000-10). 482 NAC 6-000 also establishes the Department's expectation for each Managed Care Organization's (MCO's) physical health plan (health plan), in effectively managing and monitoring the quality of care provided to clients. In addition to abiding to all provisions in this chapter, the MCO's physical health plans must abide by the provisions found in 42 CFR 438, Subpart D.

The Department (DHHS) requires that each MCO physical health plan to have an ongoing quality assessment and performance improvement (QAPI) program. The QAPI program must be approved by DHHS. DHHS will provide oversight and monitoring of the health plans QAPI programs. The health plans' QAPI programs must contain, at a minimum:

1. Description of Quality Assurance (QA) Committee structure: The Medical Director must have responsibility for overseeing the QA committee's activities. The committee must meet regularly, no less than quarterly. Membership must include MCO network providers;
2. Designation of individuals/departments responsible for the QAPI program implementation: MCOs must designate a high-level manager with appropriate authority and expertise (such as the Medical Director or designee) to oversee the QAPI program implementation;
3. Description of network provider participation in the QAPI program: MCOs must involve network providers in QAPI activities. The mechanism for provider participation must be described in the written QAPI program, and providers must be informed of their right to provide input on MCO policies and procedures;
4. Credentialing/recredentialing procedures: MCOs must institute a credentialing process for their providers that includes, at minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; and confirming that providers have not been sanctioned by Medicaid, Medicare, or other State agencies;
5. Standards of care: MCOs must develop or adopt practice guidelines consistent with current standards of care and meet the requirements of 42 CFR 438.236;
6. Standards for service accessibility-MCOs must develop written standards for service accessibility, which meet the standards established by DHHS (See 482-000-11);
7. Medical records standards: The QAPI program must contain a description of the medical records standards adopted by the MCO;
8. Utilization review procedures: Utilization review policies and procedures must be in accordance with the requirements set forth in 471 NAC 2-002.01;
9. Quality indicator measures and clinical studies: The QAPI program must have mechanisms which measures and reports to DHHS its performance, using standards measures required by DHHS (See 482-000-11);
10. QAPI program documentation methods: The QAPI program must contain a description of the process by which all QAPI activities will be documented, including Performance Improvement Projects (PIP), medical record audits, utilization reviews, etc;

11. Integration of quality assurance with other management functions: To be effective, quality assurance must be integrated in all aspects of MCO management and operations. The QAPI program must describe the process by which this integration will be achieved; and
12. Corrective Action Plans: The QAPI program must contain a description of the provisions for making necessary changes through corrective action plans.
13. Health Information Systems: The QAPI program must maintain a health information system that is capable of the following:
    a. Collects data on client and provider characteristics specified by DHHS;
    b. Collects data on services furnished to clients through an encounter system (see 482 NAC 6-005 Submission of Encounter Data);
    c. Ensures that data received from providers is accurate and complete;
    d. Collects, analyzes, integrates, and reports data; and
    e. Evaluates the impact and effectiveness of the QAPI program.

Each MCO physical health plan must make all QAPI records, including its findings and data available to DHHS. While DHHS considers all information provided by the health plans subject to the Nebraska Public Records Act, DHHS will only provide information regarding the NHC in the aggregate.

DHHS, its contracted entities or designees, or the Centers for Medicare and Medicaid Services (CMS) officials may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under the NHC.

6-002 CONTINUOUS QUALITY ASSURANCE/QUALITY IMPROVEMENT: DHHS's Quality Strategy includes continuous assessment of how well the managed care program is meeting the Quality objectives, how, based on the results of the assessment activities, DHHS will attempt to improve the quality of care delivered by the health plans, and how DHHS reviews the effectiveness of the Quality Strategy and revises it accordingly.

6-002.01 Purpose/Goal: The overall goal of the NHC's Quality Strategy is to continuously improve the quality of care and services provided to all clients enrolled in the NHC and to identify and act upon opportunities for improvement. The NHC will promote the delivery of health care services in accordance with required access standards, standard performance measures, established benchmarks, and comparisons in order to improve quality of care provided to clients.

6-002.02 Objectives: Quantifiable, performance driven objectives for demonstrating success or challenges in meeting the overall goal have been set using data that reflects health plan quality performance, access to covered services, and client satisfaction with care.

The objectives of the NHC's Quality Strategy for the Physical Health managed care include, but may not be limited to, improved access to quality care and services, improved client satisfaction, reducing racial and ethnic health disparities, and reduction/prevention of unnecessary/inappropriate utilization. (See 482-000-13).

6-002.03 Assessment: DHHS assesses and monitors the quality and appropriateness of care delivered to clients through the collection and analyses of data from many sources. The health plans are required to maintain Health Information Systems that collects, analyzes, integrates, and reports data. The health plans must also have information systems that collect data on client and provider characteristics and on services furnished to clients through an encounter data system.

DHHS will utilize, but is not limited to the following sources for assessment and monitoring of quality and appropriateness of care:

1. Quality of Care Reporting Requirements;
2. Access Standards Reporting Requirements;
3. Client Satisfaction Surveys;
4. Utilization Reporting Requirements;
5. Encounter Data;
6. External Quality Review-Technical Report;
7. Clinical Standard Guidelines;
8. On-site Operational Reviews; and
9. Performance Improvement Projects;

(See 482-000-11).

6-002.03A Operational On-site Review: Operational reviews are conducted for each MCO annually. The reviews are designed to supplement other DHHS monitoring activities by focusing on those aspects of health plan performance that cannot be fully monitored from reported data or documentation. The operational reviews focus on validating reports and data previously submitted by the MCO through a series of review techniques that include assessment of supporting documentation and conducting more in-depth review of areas that have been identified as potential problem areas.

Additionally, DHHS staff conduct random reviews of each MCO notification of adverse actions to ensure the MCO is notifying the client in a timely manner.

Furthermore, the operational review is used to validate the MCO's accreditation status, and to identify area of noteworthy performance and accomplishment.

Components of the operational reviews include, but are not limited to, an in-depth review of each MCO's Quality Management Work Plan, review of cultural competency, general administration, and delivery system.

6-002.03B External Quality Review (EQR): DHHS is required to contract with a qualified External Quality Review Organization (EQRO) to perform an annual external quality review for each contracting MCO. The EQRO is independent from DHHS and from the MCOs. The EQRO must annually:

1. Validate performance improvement projects required by DHHS that were underway during the preceding 12 months;
2. Validate MCO performance measures reported to DHHS during the preceding 12 months; and
3. Conduct a review to determine MCO compliance with standards.

The results of the EQRO reviews will be used in assessing and monitoring the quality and appropriateness of care provided to clients as part of DHHS's Quality Strategy.

6-002.04 Determination of Contract Compliance: DHHS has developed a comprehensive program to assess all aspects of MCO performance. The program involves routine analysis and monitoring of quality of care, reporting data, access standards data, and utilization data submitted by the MCOs; on-site operational reviews; analysis; analysis of client satisfaction data; and analysis of encounter data. DHHS also monitors compliance with submission of encounter data.

MCO's are considered out of compliance if they fall below the established standards for quality of care, access, client satisfaction, utilization, and encounter submission.

6-002.04A Violations Subject to Intermediate Sanctions: In addition, the following violations are grounds for intermediate sanctions that may be imposed when the MCO acts or fails to act as follows:

1. The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract;
2. The MCO imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
3. The MCO acts to discriminate among enrollees on the basis of their health status or need for health care services;
4. The MCO misrepresents or falsifies information that it furnishes to CMS or to the State;
5. The MCO misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
6. The MCO fails to comply with the requirements for physician incentive plans, if applicable;
7. The MCO has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information; or
8. The MCO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

6-002.04B Enforcement: MCO's that are determined to be performing below quality standards through periodic reporting, performance measures, client satisfaction surveys, encounter data submission, on-site operational review, and/or review and analysis of the Quality Management Work Plan will be required to submit a Plan of Correction (POC) which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up reporting is required by the MCO to assess progress in implementing the Plan of Correction.

If the MCO has not come into compliance upon completion of the POC, additional actions will be taken against the MCO. These additional actions include:

1. Instituting a restriction on the types of enrollees;
2. Changing the auto assignment algorithm to limit the number of enrollees into the plan; and/or
3. Ban new auto-assignments to the plan.

6-002.04C Intermediate Sanctions: DHHS will impose the following sanctions for violations subject to intermediate sanctions listed in 482 NAC 6-002.04A:

1. Civil monetary penalties in the following specified amounts:
    a. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to clients, potential clients, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations;
    b. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statement to CMS or DHHS;
    c. A maximum of $15, 000 for each recipient DHHS determines was not enrolled because of a discriminatory practice, subject to the $100,000 overall limit;
    d. A maximum of $25,000 or double the amount of the excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DHHS must deduct from the penalty the amount of overcharge and return it to the affected client.
2. Appointment of temporary management as described in Section III.Y of the MCO contract;
3. Granting clients the right to terminate enrollment without cause and notifying the affected clients of their right to disenroll;
4. Suspension of all new enrollment, including default enrollment, after the date of the effective date of the sanction; and
5. Suspension of payment for clients enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to occur.

6-002.05 Improvement: Based on the results of assessment and monitoring of quality and appropriateness of care and contract compliance, DHHS will target improvement efforts. DHHS will utilize, but is not limited to the following interventions to improve the quality and appropriateness of care:

1. Quality Committee: DHHS has established a Quality Committee. See 482 NAC 6-003;
2. Performance Improvement Projects (PIP): MCO plans are required to conduct at least one PIP annually. For each PIP, DHHS with the Quality Management Committee will choose the topic, develop the study methodology and determine interventions to reach improvement goals. Each plan will conduct the same PIP (See 482-000-11);
3. Quality Performance Dashboard: In an effort to monitor MCO plan performance on quality measures, a quality performance dashboard was developed. The dashboard approach provides a framework for benchmarking performance and assists MCO plans to prioritize quality improvement planning. The dashboard gives a multi-dimensional view of plan performance by comparing quality measures to national standard measures, if appropriate, to baseline measures for the program, and over two years. The dashboard results are display on the DHHS website;
4. MCO Sanctions-See 482 NAC 6-002.04.

6-002.06 Review of Quality Strategy: The Quality Committee (See 482 NAC 6-003 Quality Committee) will review the effectiveness of the overall quality strategy every three years and make recommendations for improvement. The review and analysis of the overall Quality Strategy and objectives will use data from the assessment activities described in 482 NAC 6-002.3. DHHS staff will review data and provide reports to the Quality Committee in the aggregate.

Data related to on-going quality performance of the MCO's will be collected and analyzed on an ongoing basis. Trends and comparisons with standards and benchmarks that are established will be reviewed continually. The Quality Committee will also review annually the data relating to the performance of the MCO's and make recommendation for improvement or enforcement action. Examples of these data include results of performance measures, performance improvement projects, results of the EQRO technical reports, and required data reported by the MCO's related to quality, access, utilization, and satisfaction.

As changes to the Quality Strategy are made, these changes will be reported to CMS. As the Quality Strategy evolves, challenges and successes that result in changes will be documented.

6-003 QUALITY MANAGEMENT COMMITTEE: DHHS has established a Quality Committee for physical health consisting of Department staff, Medicaid staff, Public Health staff, MCO plans, providers, and other stakeholders. The Quality Committee meets annually to review data and information designed to analyze the objectives of the Quality Strategy, and recommend actions to improve the quality of care, access, utilization, and client satisfaction.

The Quality Committee also reviews the results of the MCO's Performance Improvement Projects and determines future PIP topics, study methodologies, and recommends improvement goals, and interventions to reach improvement goals. The Quality Committee also determines if the MCO has achieved sustained improvement.

Finally, the Quality Committee reviews the effectiveness of the overall strategy every three years and makes recommendations for improvement.

6-004 ACCREDITATION: The MCOs must have NCQA Accreditation or another national accreditation for the Medicaid Managed Care plan. MCOs must submit a copy of the accrediting body's letter indicating the most recent accreditation status at the time of initial contracting. Any changes or updates must be sent to DHHS within 30 days of receipt.

Upon survey by the accrediting body, the MCO must submit a copy of the survey results to DHHS within 30 days of receipt. The MCO must submit a copy of any work plan that addresses improvements needed or follow-up necessary as a result of the survey. Any changes or updates to the survey results or work plan must be submitted to DHHS within 30 days of receipt.

In the event that the MCO's specific Medicaid Managed Care plan is not accredited at the time of contracting, the MCO is required to submit to DHHS the plan to be fully accredited within the three-year contracting period. The MCO must submit a work plan including the timeline to accomplish plan accreditation to DHHS. The MCO must provide a status update to DHHS staff at the time of the annual on-site operational review.

6-005 SUBMISSION OF ENCOUNTER DATA: DHHS requires the MCOs to submit encounter data to the Medicaid Management Information System (MMIS) per DHHS specifications. The MCOs must also participate in all encounter data review and technical-readiness assessments.

Encounter data submission must:

1. Be submitted on a monthly basis;
2. Be submitted accurately and meet the DHHS standard of 95% submission rate;
3. Include all clean claims adjudicated by the MCO; and
4. Include all services provided to the NHC clients, contracted or delegated.

Encounter data that does not meet the 95% submission rate will be rejected and returned to the MCO. The MCO is required to re-submit corrected encounter data in a timely manner. MCO's which fail to meet compliance standards for submission of encounter data for three consecutive months will have the auto assignment algorithm changed to limit enrollment in the physical health plan until the MCO plan comes into compliance.

Reports of encounter data are used by DHHS to provide a source of comparative information for MCO's and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, and cost effective analysis.