Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

HERITAGE HEALTH

Heritage Health Quality Management Committee
Agenda

Meeting Date / Time	**Wednesday, June 8, 2016; 11:00 am 1:00 pm**
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68508
Conference Line	(888) 820 – 1398 Access Code : 7908970#

Agenda:

Topics	Facilitator
Welcome and Introductions	Calder Lynch
Charter and Membership Review	Calder Lynch
Heritage Health RFP – Quality	Heather Leschinsky
MLTC Dashboard Presentation	Aaron Ziska
Nebraska Total Care Quality Presentation	Stacy Lagemann, Quality Improvement Manager
WellCare Quality Presentation	Nick D'Ambra, Quality Improvement Project Manager Kim Wooten, Senior Quality Improvement Project Manager
UnitedHealthcare Community Health Plan Quality Presentation	Michael J. Horn, MD MMM; Chief Medical Officer
Future Meeting Topics General Q & A – Committee Members	Calder Lynch
Public Comment	Open
Action Item Assignments, Closing Remarks	Calder Lynch
Adjourn	Calder Lynch

Next Meeting

Meeting Date / Time	**Thursday, September 15, 2016; 1:00 pm 3:00 pm**
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68508
Tentative Agenda Topics	TBD

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

HERITAGE HEALTH

Quality Management Committee Roster

Committee Member	Title	Organization	Email Address
Jeanne Alicandro, M.D.	Medical Director	IPRO	jalicandro@ipro.org
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Fernando Wilson, PhD	Associate Professor	University of Nebraska Medical Center, College of Public Health	fernando.wilson@unmc.edu

*Interim member

Quality Management Committee

DHHS Division of Medicaid and Long-Term Care (MLTC)

MISSION

The Quality Management Committee (QMC) advises MLTC on clinical and operational quality initiatives and provides oversight of the Heritage Health quality management program.

GUIDING PRINCIPLES

- Heritage Health members should enjoy the highest level of care quality.
- Quality improvement initiatives should focus on achieving optimal clinical and operational outcomes.
- Quality measurement selection should reflect input from diverse sources including comprehensive operational and clinical reporting, consultations with medical experts, and feedback from members, providers, and other stakeholders.

CORE FUNCTIONS

- Recommend measurements and provide ongoing monitoring for a dashboard of key performance indicators to be compared against established benchmarks.
- Monitor Medicaid managed care organizations' (MCOs) quarterly and annual quality reports and make recommendations for improvement or enforcement.
- Review and recommend updates to MLTC's Quality Strategy Plan.
- Review results of the MCOs' performance improvement projects (PIPs) and make recommendations for improvements.
- Recommend topics for new PIPs.
- Recommend actions to improve the quality of care, access, utilization, and client satisfaction.
- Recommend actions to improve member satisfaction.
- Form subcommittees to address special quality related issues as needed.

MEMBERSHIP

The QMC will include broad representation from medical experts, providers, patient and community advocates, managed care contractors, and State program administrators and systems and policy experts. Members, excluding those representing the State or MCOs, will serve two-year terms.

Committee Participants

- Participant categories will be added based on final membership list.

MEETINGS

The QMC will hold its initial meeting on June 8, 2016. Additional meetings are scheduled for:

- September 15, 2016
- December 8, 2016
- March 8, 2017
- June 7, 2017

GUIDANCE

- 2017 MLTC Quality Strategy (under development)
- Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measures
- CMS (Adult and Child) Core Set of Healthcare Quality Measures
- Federal regulations 42 CFR 431, 433, 438, 440, 457 and 495
- CMS proposed rule changes for Managed Care
- National Committee for Quality Assurance (NCQA)
- External Quality Review (EQR) Technical Reports
- Nebraska Administrative Code NAC 471
- MCO's Quality Management Program, including Quality Assurance and Improvement (QAPI) Program; PIPs; Quality Performance Measurement and Evaluation; Member and Provider survey results; MCO Accreditation Requirements.

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

HERITAGE HEALTH

Quality Management Committee
Meeting Schedule

Meeting dates, times, and locations for the Quality Management Committee are included in the table below.

Date	Time	Location
June 8, 2016	11:00 AM to 1:00 PM, Central Time	Nebraska State Office Building 301 Centennial Mall South Lower Level Room A Lincoln, NE 68509
September 15, 2016	1:00 PM to 3:00 PM, Central Time	Nebraska State Office Building 301 Centennial Mall South Lower Level Room A Lincoln, NE 68509
December 8, 2016	1:00 PM to 3:00 PM, Central Time	To be determined.
March 8, 2017	10:00 AM to 12:00 PM, Central Time	To be determined.
June 7, 2017	10:00 AM to 12:00 PM, Central Time	To be determined.

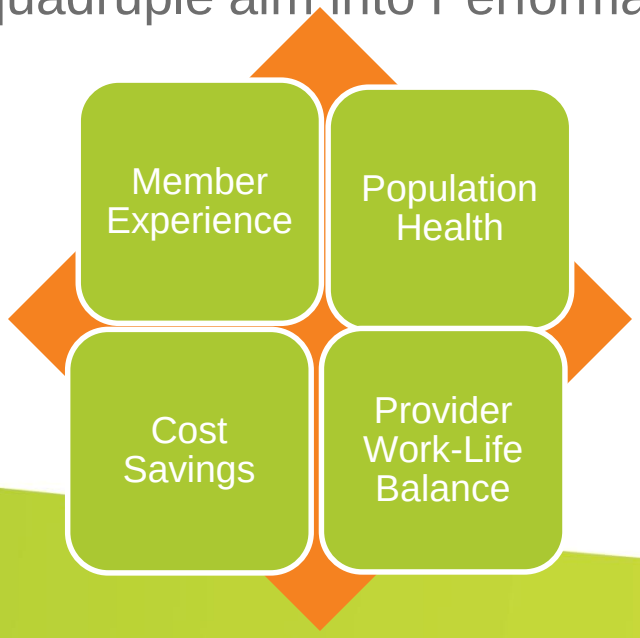
Quality Management

Program Overview

06/14/2016

Quality Management Strategy

- Our mission is to transform the health of the community one member at a time.
- Our goal is to improve the member's health status through a variety of impactful quality management activities implemented across all care settings and aimed at improving quality of care and services delivered.
- Incorporate the quadruple aim into Performance Improvement Activities



Quality Management Strategy

- Member safety is a priority- utilize Program Data to continuously monitor Quality of Care and Services

- Utilize nationally recognized, evidence-based practices in our Quality Program and throughout the organization.

- Culture of Quality integrated in Executive, Management and Staff meetings. *All NTC divisions share accountability for improving clinical outcomes as well as member and provider experience scores impacting health plan performance.*

Quality Management Strategy

- Leverage proven, impactful interventions and implement customized quality interventions focused on enhancing member and provider engagement

- NTC identifies opportunities, selects focus areas reflecting the needs of members, designs and implements programs that integrate physical and behavioral health.

"I thought I was on to something but I can't figure out how to move it."

We don't need to recreate the wheel for all QM Initiatives

Integrating the Quadruple Aim into the QAPI Program

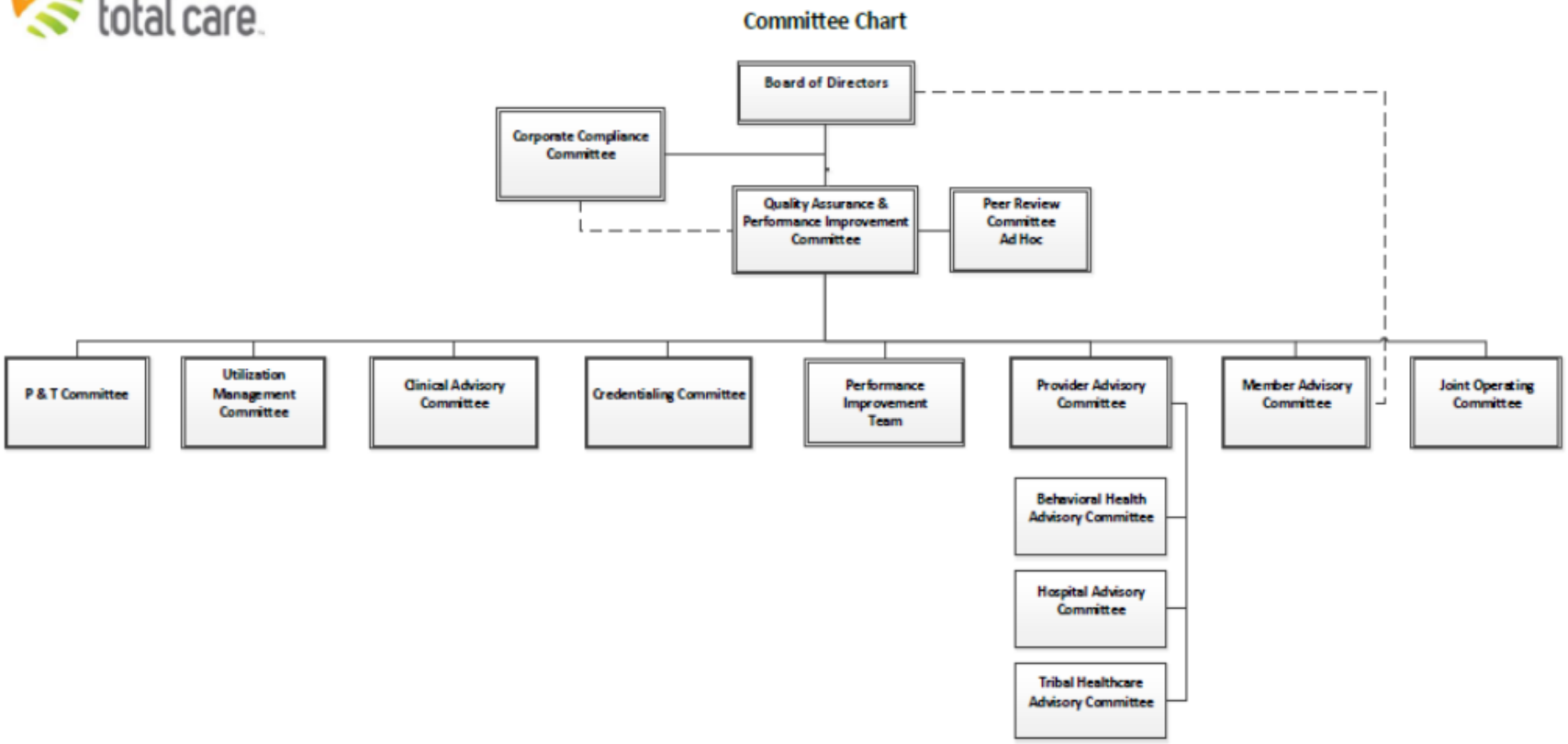
- **Member Experience**
  - Consumer Assessment of Healthcare Providers and Systems –CAHPS [CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ)]
  - Grievances and Appeals
  - Member Advisory Committee and direct input from members
  - Member incentives
- **Population Health**
  - Adoption of evidence-based clinical indicators and practice guidelines
  - Preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews and other focused studies
  - Clinical Performance measures – Healthcare Effectiveness Data and Information Set (HEDIS) and Adult/Child Core measures [HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)]
  - Patient Safety and preventive health reminders
  - Chronic care, integrated care management and complex care management

Integrating the Quadruple Aim into the QAPI Program

- **Cost Savings**
  - Evaluate the QAPI Program and QAPI Work Plan annually to assess whether program objectives were met; recommend adjustments when necessary
  - Promote participating providers' compliance with UM criteria and clinical practice guidelines
  - Utilize Clinical Outcomes Unit
  - Promote early disease detection and improve outcomes for members, while increasing members' choice in providers and treatment modalities, to improve the quality of care
  - Monitor continuity of care
  - Monitor for trends indicating potential over and under utilization

- **Provider Work Life Balance**
  - Provider incentive programs designed for current state provider performance and built to advance performance
  - Provide a tailored program of tools needed to accomplish quality goals, improve care coordination and health care outcomes, and engage members in making good health care choices.
  - Provide meaningful and timely information (scorecards) and insights to providers on their populations
  - Track performance over time and help identify opportunities for improvement thru provider profiling
  - Provide complementary skill sets (e.g., care coordination, UM) that are appropriately tailored to meet the needs of providers and support their efforts to care for their patients.

Quality Management Structure

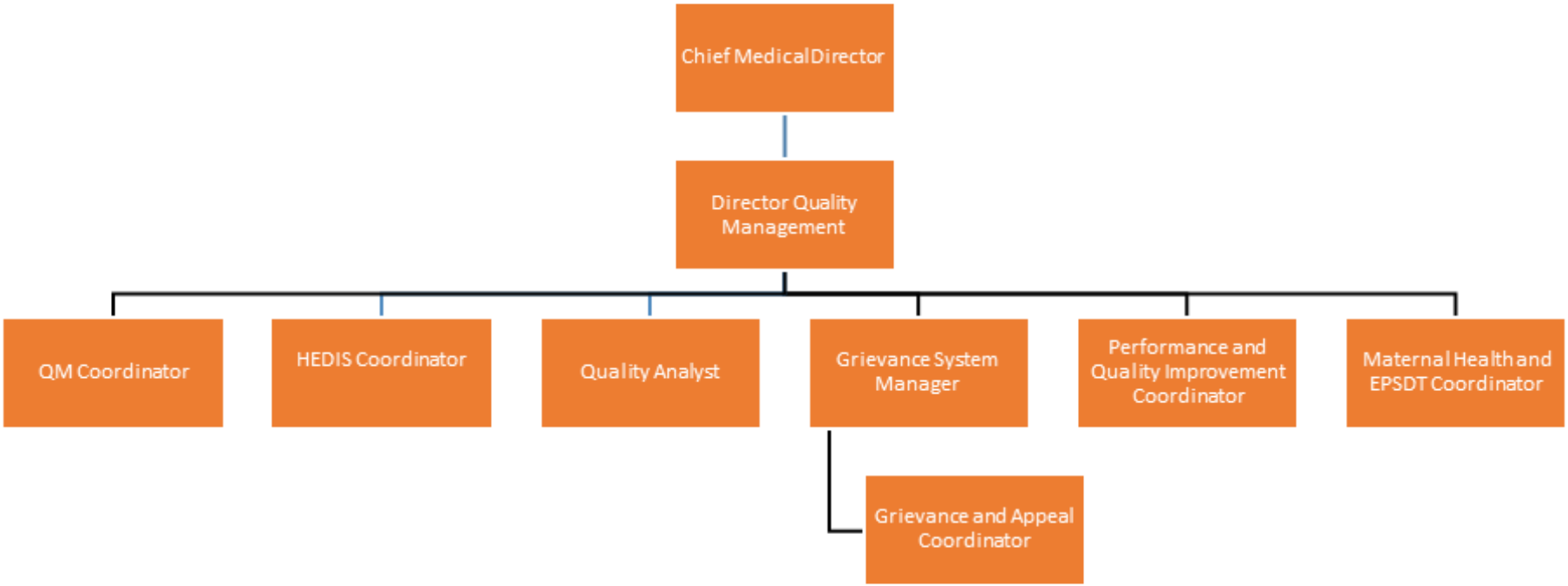


Quality Program Resources

The Management Information Systems (MIS) supporting the QAPI Program allow key personnel the necessary access and ability to manage the data required to support the measurement aspects of quality improvement activities.

NTC has access to a comprehensive family of integrated decision support and health care informatics solutions. The platform integrates data from internal and external sources, producing actionable information: from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and numerous unique operational and state compliance reports.

Quality Program Staffing



Quality Contact Information

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Mary Kay Jones, Vice President Quality Improvement
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Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Quality Management Committee

June 8, 2016

UnitedHealthcare®
Community Plan

Our United Culture

UnitedHealthcare Community Plan

Our mission is to help people live healthier lives.
Our role is to make health care work for everyone.

Integrity.	Honor commitments Never compromise ethics
Compassion.	Walk in the shoes of people we serve and those with whom we work
Relationships.	Build trust through collaboration
Innovation.	Invent the future, learn from the past
Performance.	Demonstrate excellence in everything we do

Our Team is Committed to Quality

UnitedHealthcare Community Plan

Our Mission: Helping People Live Healthier Lives.

Integrity | Compassion | Relationships | Innovation | Performance




Quality is helping our members receive the care they need.

- ✓ A personal, meaningful member experience
- ✓ Improved outcomes
- ✓ Simplify the system
- ✓ Right care at the right time
- ✓ Shared responsibility
- ✓ Collective commitment to our members

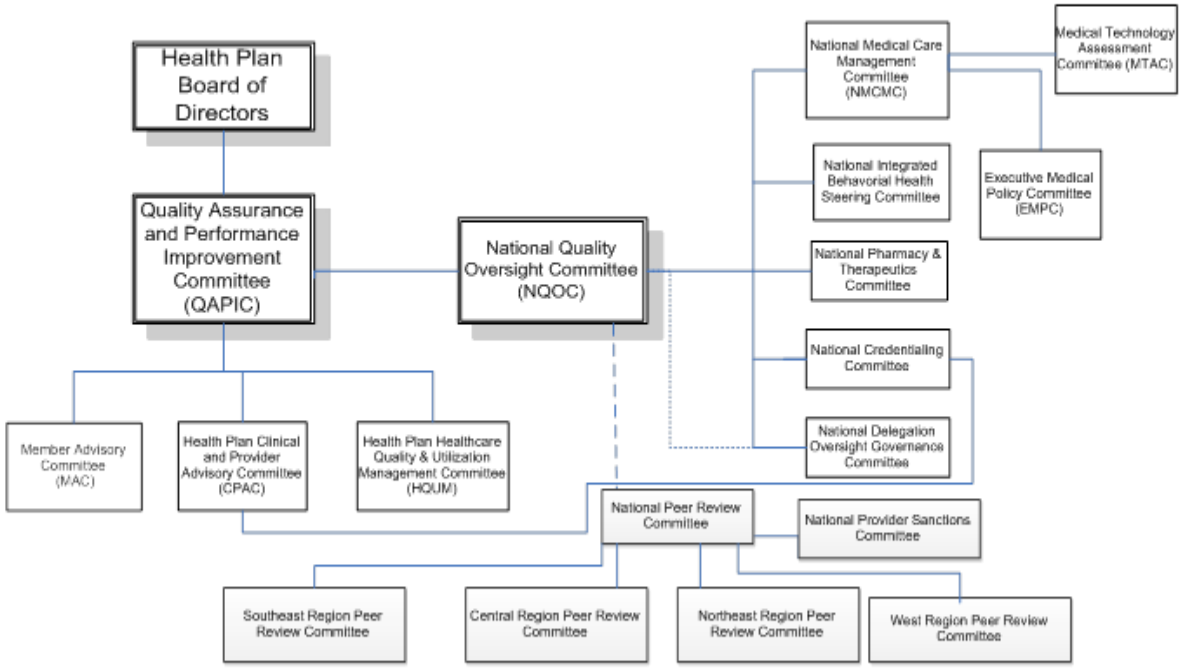
Quality Strategy…. to continuously improve the quality of care and service provided with a person-centered approach

UnitedHealthcare Community Plan

Program Objectives:

- Promote and incorporate quality into the health plan's organizational structure and processes
- Provide effective monitoring and evaluation of patient care and services provided by practitioners/providers for compatibility with evidenced based medicine guidelines
- Identify and analyze opportunities for improvement and implement actions and follow-up.
- Coordinate quality improvement, risk management, patient safety and operational activities
- Maintain compliance with local, state and federal regulatory requirements and accreditation standards
- Serving culturally and linguistically diverse populations in Nebraska
- Monitoring and improving quality indicators
- Serving members with complex health needs

Quality Structure – Current State



Quality Approach

High Touch

Building *Relationships* Through *Compassion*

- CHWs
- Navigators

High Tech

Innovative Interactions

Member & Provider

- Text
- Email

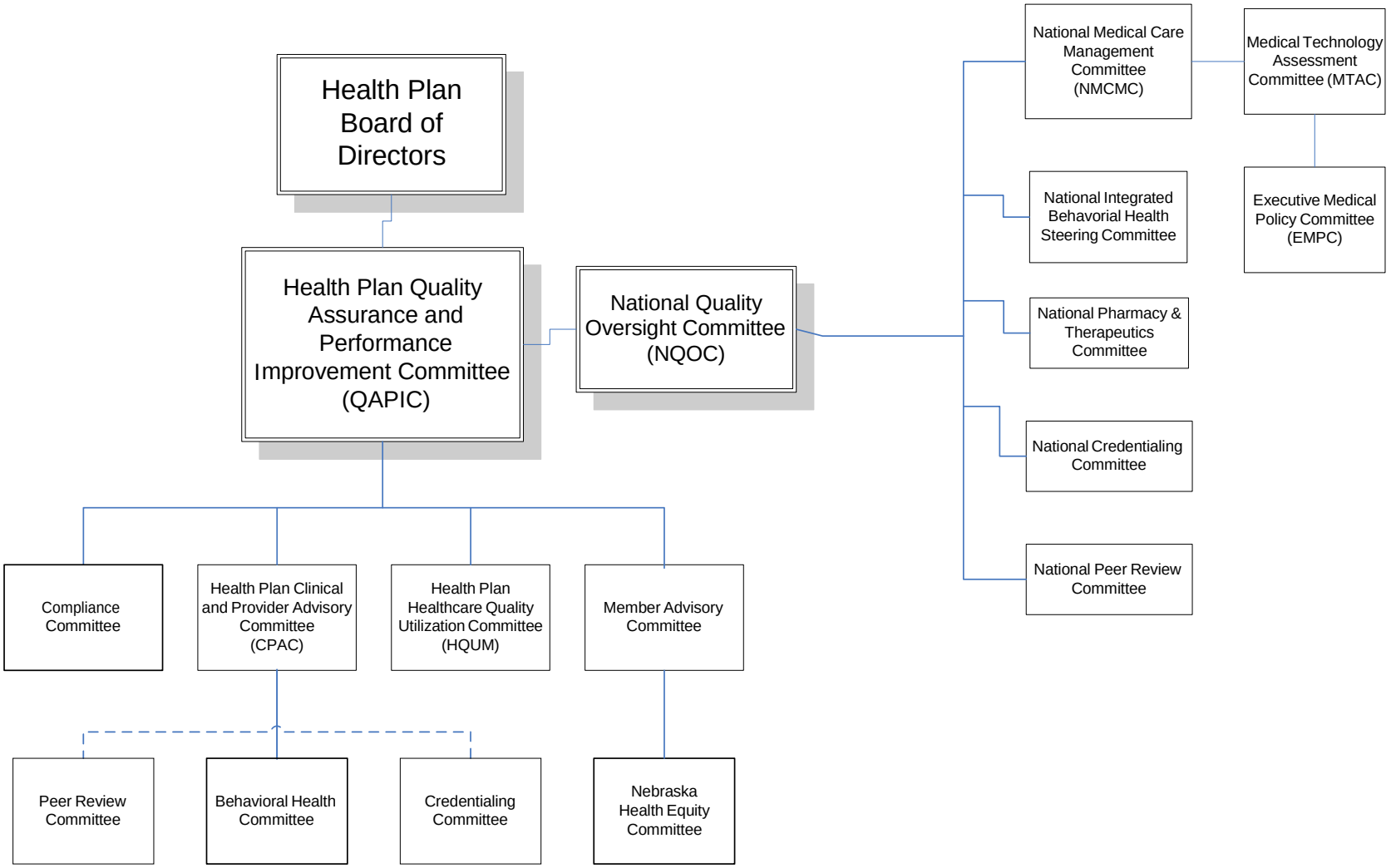
High Trust

Measured *Performance,* Actions, & *Integrity*

- CPCs
- Gap Reports

Helping People Live Healthier Lives

Quality – Future State



Quality Facts

UnitedHealthcare Community Plan

- Accredited by the National Committee for Quality Assurance (NCQA) since Aug. 12, 2005
- Current Accreditation Status Commendable
- Successful EQRO Audits
- Engaged Provider participation on our Physician Advisory Committee since 2005
- Health Plan quality committees address utilization management, care management and all member and health plan services
- Active Member Advisory committee since 2012

In Summary

UnitedHealthcare Community Plan

Broadly Based Quality Program Guided By The Triple Aim Focus







Focus on high quality care to improve **member health outcomes**

Development of holistic, person-centered, recovery oriented care to address medical, behavioral, and social needs to **improve overall care experience**

A comprehensive service delivery model provides early identification of individual needs thus **lowering health care costs**

Contacts

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Nebraska Quality Management Overview

June 8, 2016

Quality Management Committee

Facilitated by:
Nicolas D'Ambra Quality Improvement Project Manager
Kimberly Wooten Senior Quality Improvement Project Manager

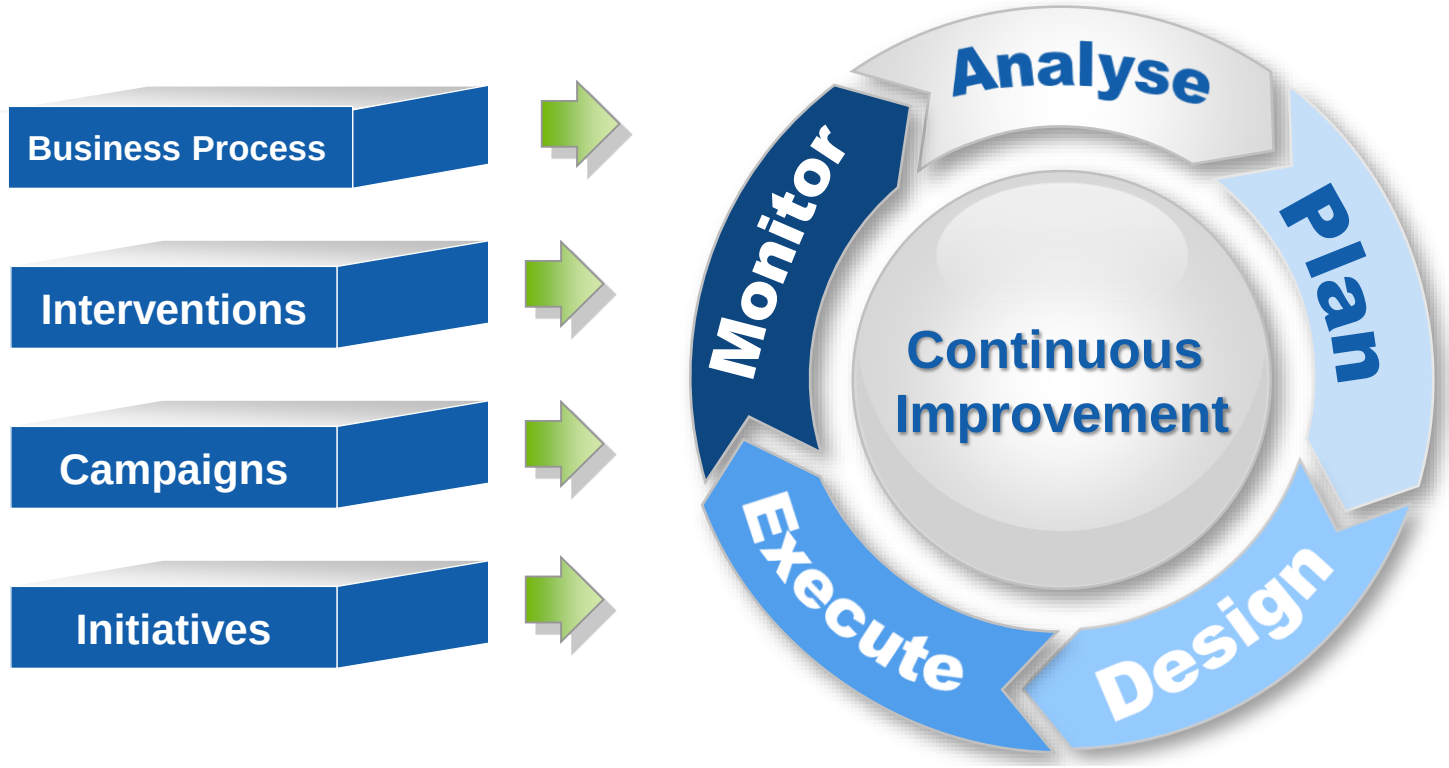
WellCare of Nebraska

Quality Management Strategy

WellCare's core mission is to provide for high-quality care that improves our members' well-being as well as enhance population health outcomes for the communities we serve by partnering with members, providers, PCMH, advocacy groups, community-based organizations, state and local agencies, and stakeholders.

- Fully Integrated Quality Program
  - Quality is fully integrated into each area that impacts the member in order to provide a collaborative approach to member care
  - Examples of areas that Quality is partnered with are:
    - Behavioral Health – improve member's quality of life by providing early intervention on co-occurring conditions
    - Care Management
    - Community Advocacy – coordinates to provide a comprehensive social support network
    - Disease Management
    - Grievance & Appeals – Quality of Care investigations and reporting
    - Network Development & Management – Access & Availability, PCMH incentive alignment
    - Operations – centralized telephonic outreach program
    - Pharmacy – medication adherence measure program
- Person-Centered Focus
  - Empowering members to help make a difference in their preventive health outcomes
  - Affecting population behaviors with incentive programs tailored to specific needs such as the Healthy Behaviors Program and Maternity Education and Reward Program

Quality Management Strategy: Philosophy of Continuous Quality Improvement



WellCare uses the Plan-Do-Study-Act (PDSA) method of continuous quality improvement throughout the organization. Under the PDSA approach multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause/barrier analysis is conducted, development of new or redesign of existing interventional methodologies are implemented, and re-measurement occurs to ensure progress toward established goals. Continuous Quality Improvement (CQI) processes are used to develop the QAPI Program Description, Work Plan, and Program Evaluation.

Quality Management: Functional Org Chart

Area	Roles & Responsibilities
Health Services Quality & Analytics	Clinical Quality Program Design & Implementation Clinical HEDIS® Project Management Oversight Campaign/Initiative Development & Oversight
Quality Reporting & Analytics	HEDIS® Monthly Tracking & Trending, Data Integration, and Annual Reporting CMS Adult & Child Core Set Measure Reporting CMS 416 Reporting State-Specific Performance Measure Reporting Performance Improvement Project (PIP) Data Analysis Analysis of Member/Provider Data for the Development of Interventional Methodologies Care Gap Reports Provider Segmentation Reports Pay for Quality (P4Q) Geo-Analysis for Care Gap Heat Mapping
Quality Accreditation & Audit	EQRO Activities & Audits NCQA Accreditation Internal Compliance File Audits – Appeals/BH/CM/UM
Quality Strategic Initiatives	Operational Coordination Strategic Initiative Implementation & Oversight

WellCare of Nebraska

Performance Improvement Projects (PIPs)

PIPs address aspects of care and service to members that are expected to have positive effects on health outcomes and member satisfaction. PIPs are developed in collaboration with the EQRO, State partners and stakeholders. Progress of each PIP is reported quarterly and an annual PIP report is completed by the Plan and submitted to the EQRO and State for review and approval.

- Clinical PIP topic examples: Obesity, diabetes, prenatal/postpartum, and smoking cessation
- BH Clinical PIP topic examples: Antipsychotic medication use in children & adolescents, BH medication use in children, 7-day follow up after mental health admission, initiation and engagement of alcohol and other drug dependence treatment
- Non-Clinical PIP topic examples: Member & Provider satisfaction, hotline & call center statistics, turn around time for grievances
- Collaborative PIP topic examples: EPSDT, obesity, dental, community health workers, clinical practice guidelines (ADHD, asthma, and diabetes)

Health*Connections*

CommUnity Activities: community-based health and wellness events.

Health*Connections* Councils: community planning councils focused on highlighting the role of the Social Safety Net in delivery quality and cost-effective healthcare.

Social Service Utilization Support: facilitating member connections to social services and bridging gaps in service availability.

CommUnity Health Investment Program: grants for social innovation.

Social Service Study

Robert Wood Johnson Foundation's National Coordinating Center for Public Health Systems and Service Research

- Study Population: Nearly 8,400 Managed Care consumers with at least one social service referral (CY 2013-15)
- Results: Participants referred to an average of 3 social services each with an 18% access rate.
- Impact: Estimated savings of $450 per social service accessed

WellCare of Nebraska

Impacting Change Locally: Clinical HEDIS® Practice Advisors (CHPA)

- Enterprise-wide there are over 80 associates whose roles are Clinical HEDIS® Practice Advisors
- CHPAs are integrated within their respective core health plan across the country
  - In Nebraska the CHPA Program will be comprised of registered nurses/allied health care professional with HEDIS® experience
- CHPAs engage high-volume providers that care for 80% of membership in a market in face-to-face and telephonic visits with a focus on impacting HEDIS® measures and clinical outcomes
- CHPAs utilize a variety of tools and skillsets including providing guidance on proper coding according to NCQA guidelines, presenting individualized care gap reports, and providing resources such as the HEDIS® Toolkits which are a comprehensive set of documents for providers to assist in understanding HEDIS® measures and coding according to NCQA guidelines
- CHPAs determine root cause or barriers prohibiting HEDIS® services from being captured in claims/encounter data, as well as educate providers on ways to capitalize on routine visits by completing well child checks, immunizations, chronic conditions, and preventive screenings during the member's appointment.

WellCare of Nebraska

Comprehensive Care Gap Program

WellCare's Care Gap Program utilizes a centralized repository which serves as single source of truth. The repository identifies members with gaps in preventive care and/or chronic conditions at the individual provider and practice group level. WellCare uses the repository to provide education and outreach to members and providers to ensure members are receiving preventive and chronic care services required. This allows for continuous trending Month-over-Month and Year-over-Year.

- Associate Engagement in the Care Gap Program
  - Care Managers – automated notifications via medical management platform
  - Inbound Member Services Representatives – automated notifications during inbound calls
  - Outbound Member Outreach Campaigns – Centralized Telephonic Outreach Program, Postpartum Outreach Program, HEDIS® Education, Screening, and Prevention Program
  - Outbound Ad Hoc Member Outreach Campaigns
  - Provider Relations Representatives
  - CHPA's
  - Community Advocates

WellCare of Nebraska

Comprehensive Care Gap Program

- Care Gap Program Tools
  - Care Gap Reports – generated monthly using available claims and encounter data to monitor provider performance and identify areas of improvement
  - Interactive HEDIS® Online Portal (iHOP) – secure provider portal where a provider can view member care gaps, render the service during the member visit, and scan/upload the medical record to substantiate that the service was rendered
  - MyWellCare Mobile Application for members – displays the top 3 care gap services available
  - Pseudoclaim Database – a tool used by associates to enter provider medical records to close existing member care gaps
  - EMR Flat File Process – provider file transfer in a proprietary file format for regular submission of member level data
  - Heat Maps – identifies geographic trends in care gaps to assist in targeting efforts

WellCare of Nebraska

Soliciting Member Feedback

- Members are encouraged and invited to actively participate in not only their experience with us but also to implement changes based on their feedback
- Members are key participants in a variety of our committees which covers topics such as:
  - Experience with customer service
  - Educational and outreach materials
  - Barriers regarding their health care
- Quality Management utilizes the valuable member feedback to determine interventions and initiatives

Member Feedback in Action

Florida: The Member Advisory Committee, comprised of active members, advocacy groups representing active members, and key staff, was engaged to help improve operations through a billing project. The project sought to reduce the incidence of providers balance billing Participants. Interventions designed and implemented delivered a 91% reduction in balance billing-related grievances in three months, exceeding the goal of 35%.

Illinois & New Jersey: The Member Advisory Committees in both states completed a survey which focused on gaining specific feedback on what members liked and did not like about using the plans' websites. The feedback revealed areas of opportunity to improve navigation for participants on the website such as the design of the "Find a Provider" tool along with state identifiers. This feedback was incorporated during the redesign of the website which added multiple new features including a state identification process and a keyword search in the "Find a Provider" tool.

Hawaii: Feedback from the Member Advisory Committee revealed that cultural sensitivities and discomfort had made it difficult for many women to have their recommended screening mammograms. The committee participants' feedback was incorporated into the resulting "Mammo Me, Mammo You" program. Through culturally appropriate education and convenient access to screenings, the program proved successful and was introduced in other parts of the State. 'Ohana's HEDIS® rate for Breast Cancer Screening subsequently increased, showing significant improvement from 49.16% to 56.43% in 2013 and 2014

Quality Management Contacts

Contact	Title	Email	Phone
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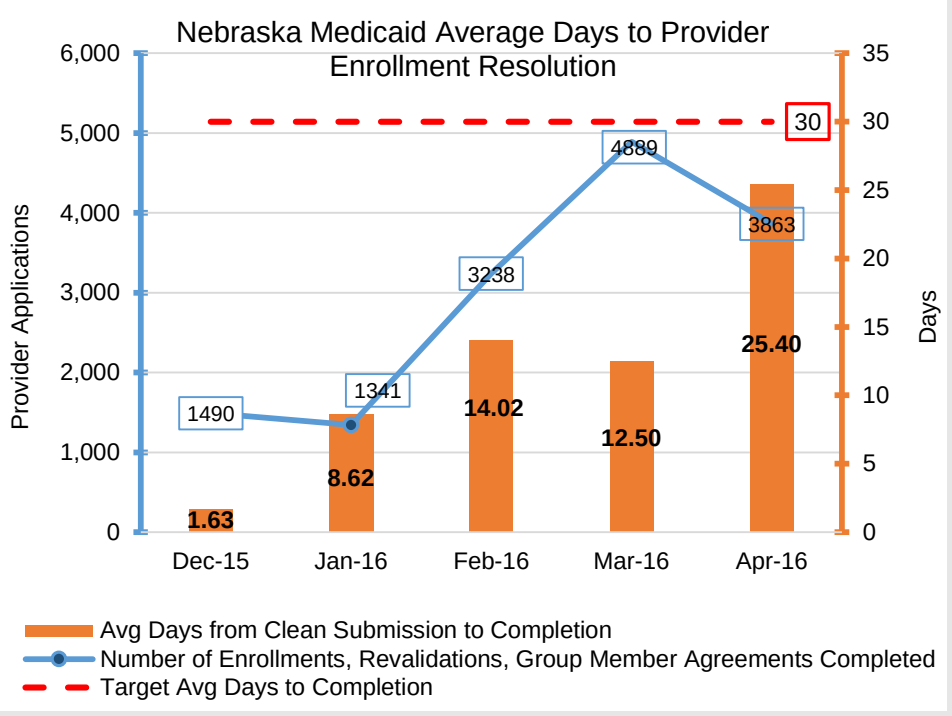
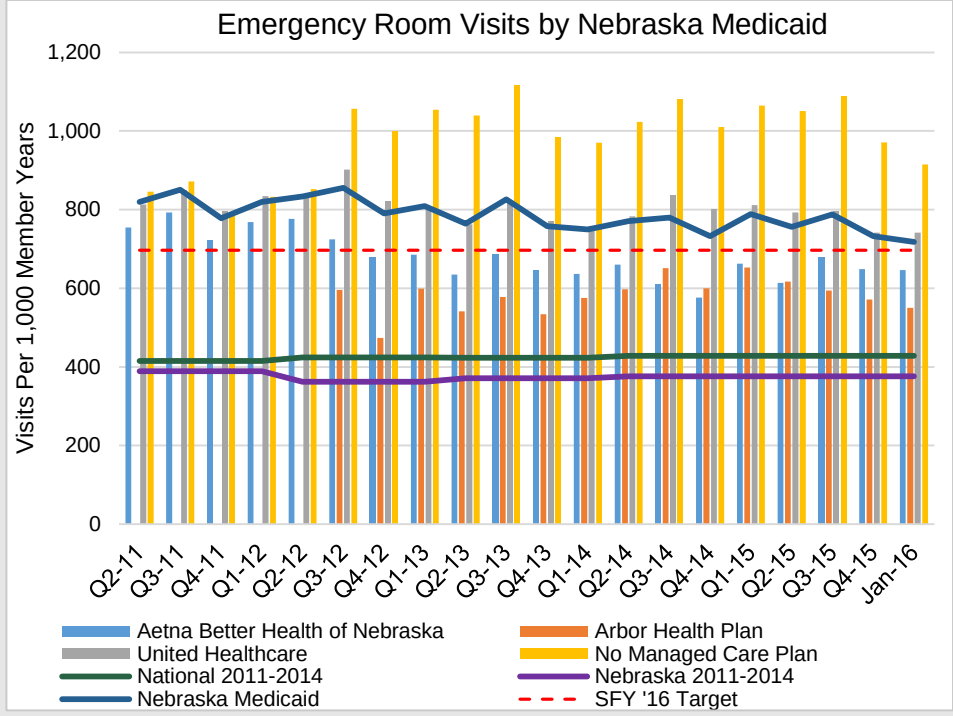
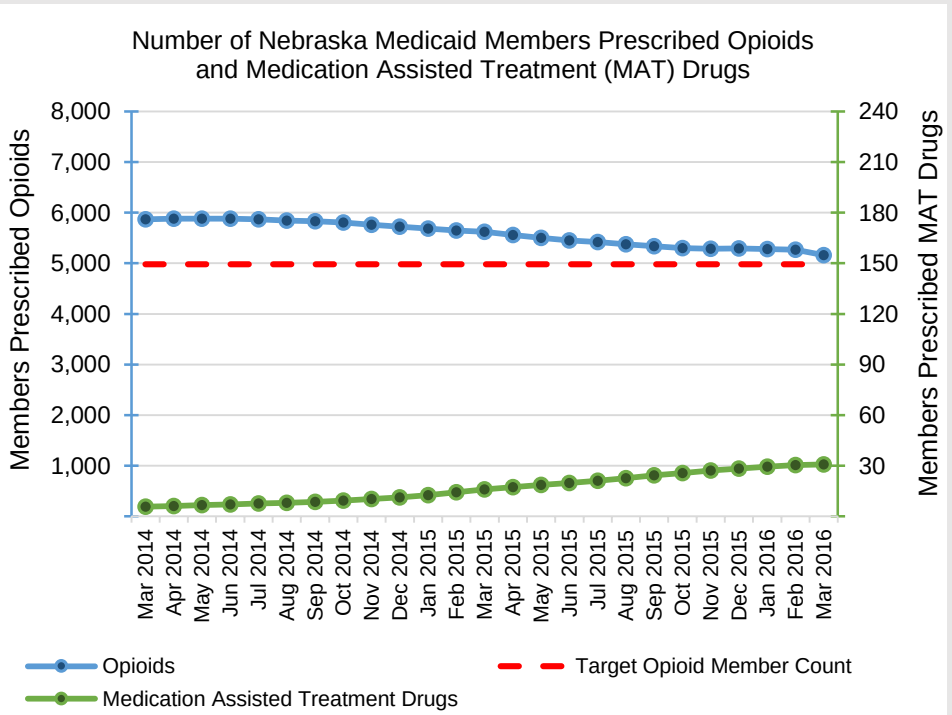
Medicaid & Long-Term Care

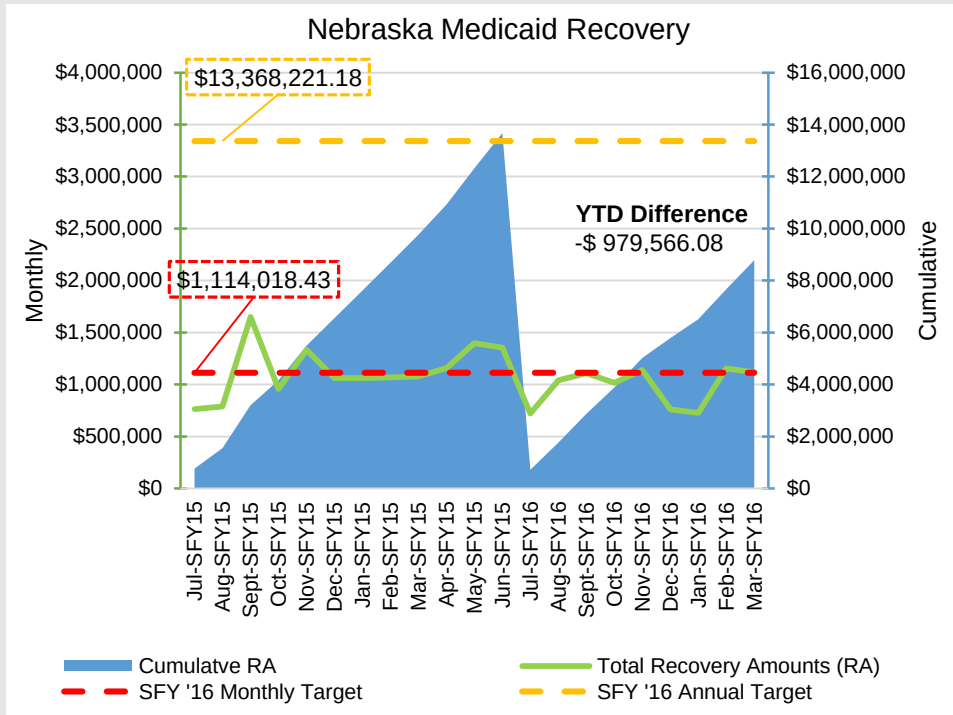
Calder Lynch, Director

Department of Health & Human Services
DHHS
NEBRASKA


Nebraska Medicaid Average Days to Provider Enrollment Resolution
Provider Applications
Days
6,000
5,000
4,000
3,000
2,000
1,000
0
35
30
25
20
15
10
5
0
30
1490
1341
3238
4889
3863
1.63
8.62
14.02
12.50
25.40
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
Avg Days from Clean Submission to Completion
Number of Enrollments, Revalidations, Group Member Agreements Completed
Target Avg Days to Completion


Emergency Room Visits by Nebraska Medicaid
Visits Per 1,000 Member Years
1,200
1,000
800
600
400
200
0
Q2-11
Q3-11
Q4-11
Q1-12
Q2-12
Q3-12
Q4-12
Q1-13
Q2-13
Q3-13
Q4-13
Q1-14
Q2-14
Q3-14
Q4-14
Q1-15
Q2-15
Q3-15
Q4-15
Jan-16
Aetna Better Health of Nebraska
Arbor Health Plan
United Healthcare
No Managed Care Plan
National 2011-2014
Nebraska 2011-2014
Nebraska Medicaid
SFY '16 Target


Number of Nebraska Medicaid Members Prescribed Opioids and Medication Assisted Treatment (MAT) Drugs
Members Prescribed Opioids
Members Prescribed MAT Drugs
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
240
210
180
150
120
90
60
30
Mar 2014
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Mar 2015
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Opioids
Target Opioid Member Count
Medication Assisted Treatment Drugs


Nebraska Medicaid Recovery
Monthly
Cumulative
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
$16,000,000
$14,000,000
$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$0
$13,368,221.18
$1,114,018.43
YTD Difference
-$ 979,566.08
Jul-SFY15
Aug-SFY15
Sept-SFY15
Oct-SFY15
Nov-SFY15
Dec-SFY15
Jan-SFY15
Feb-SFY15
Mar-SFY15
Apr-SFY15
May-SFY15
Jun-SFY15
Jul-SFY16
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Feb-SFY16
Mar-SFY16
Cumulatve RA
Total Recovery Amounts (RA)
SFY '16 Monthly Target
SFY '16 Annual Target

Governor's Dashboard Talking Points

Nebraska Medicaid Average Days to Provider Enrollment Resolution

- Over 15,000 providers enrolled as of April 30th.
- Resource director training was facilitated by MLTC and Contractor staff on April 18th and 19th.
- This chart depicts the average number of days to reach the resolution of a provider enrollment application, including new enrollment, revalidation, and group member profile agreements. It also includes the number of applications for the sum of these categories.
- Reporting for these metrics are still being refined; current figures do not depict aging of applications that have not reached completion.
- The intent of this chart is to track the average days to completion of a provider enrollment application, over time, relative to state goals.

Emergency Room Visits per 1,000 Medicaid Member Years

- MLTC has begun work coordinating with managed care organizations and the Nebraska Hospital Association to develop and implement a collaborative action plan to reduce ER visits involving these and other stakeholders.
- Aetna Better Health of Nebraska has implemented an ED Super Utilizer Project to decrease unnecessary ER usage beginning in February 2016. This program focuses on engaging patients with their primary care providers.
- This chart shows the rate of emergency room visits per 1,000 member years for Nebraska Medicaid by managed care plan. These data points are revised each month and generally will increase from month to month as claims mature within MLTCs system.
- The Medicaid plans are measured against 1,000 member years, compared to National and Statewide figures which are per 1,000 population for better degrees of comparability.
- The Statewide and National figure are sourced from the Kaiser Foundation for 2014 figures. (Most recent available at this time).
- Medicaid recipients use ER services nearly twice as much, on average leading to higher costs for this population. *Source: Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? CDC, NCHS Data Brief No 38. Garcia et al.*

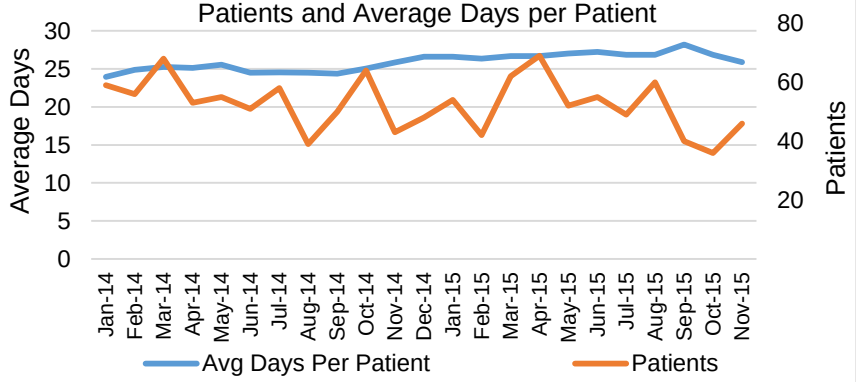
Nebraska Medicaid Recoveries

- The lower recovery amounts are partially tied to Nebraska's shift to statewide managed care.
- Programmatic impacts on the data are being researched by MLTC to review causes of lower YTD values.
- The unit's vacant management position has been filled, effective April 4th, having been vacant since January 14th.
- The new unit manager will be implementing case management performance metrics.
- This chart depicts the sum of dollar amounts applied to claims from other payers such as: commercial health insurance, casualty insurance, and Medicaid beneficiary estates.
- Monthly figures are aligned to the primary Y axis, and annual/cumulative figures are aligned to the secondary Y axis, as noted in the chart.
- There are varying levels of effort required to recover funds, dependent upon which type of third party is deemed liable.

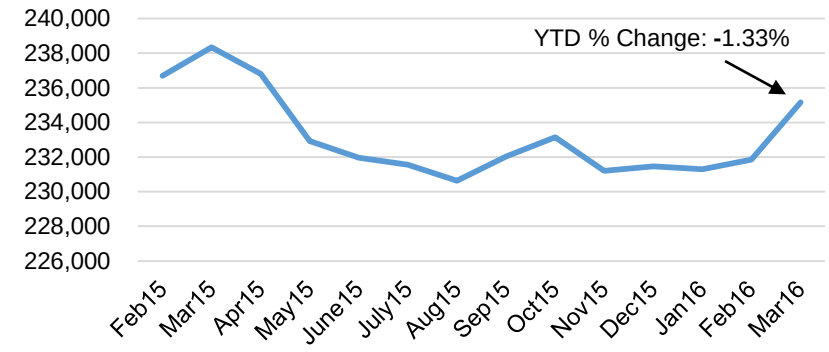
Nebraska Medicaid Opioid Tracking

- Provider intervention packets for new opiate guidelines will be mailed, tentative date of early May 2016.
- Prior authorization form for treatment medication for addiction is still in place, but has been greatly simplified. An updated form for use expected to be completed in June 2016.
- The slow downward trend of this data may be due to increased awareness of the opioid epidemic, as seen in the fall issue of Nebraska Medicine quarterly. Harris, P. A. (2015). Physicians leading fight against opioid crisis. Nebraska Medicine, 14(3), 13. Retrieved from https://www.nebmed.org
- This chart depicts the count of members receiving opioid and medication assisted treatment drug prescriptions for Nebraska Medicaid by month.
- The intent is to track the volume of Medicaid members receiving prescribed opioids relative to MLTC targets, and show the impact of MLTC interventions on the volume of the population receiving medication assisted treatment.
- The medications included were the most commonly prescribed opioids, but this list is not exhaustive.
- In order to control for volatility within the population, a 12-month moving average is used.

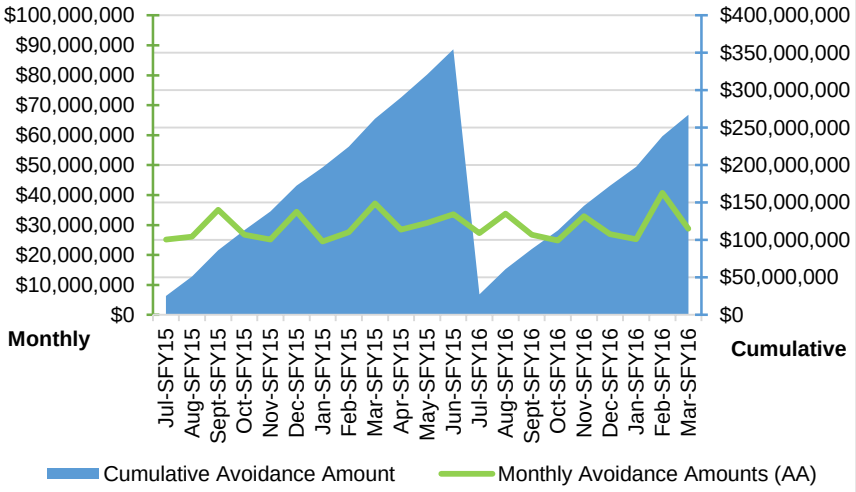
Nebraska Medicaid Neonatal Intensive Care Unit (NICU) Patients and Average Days per Patient



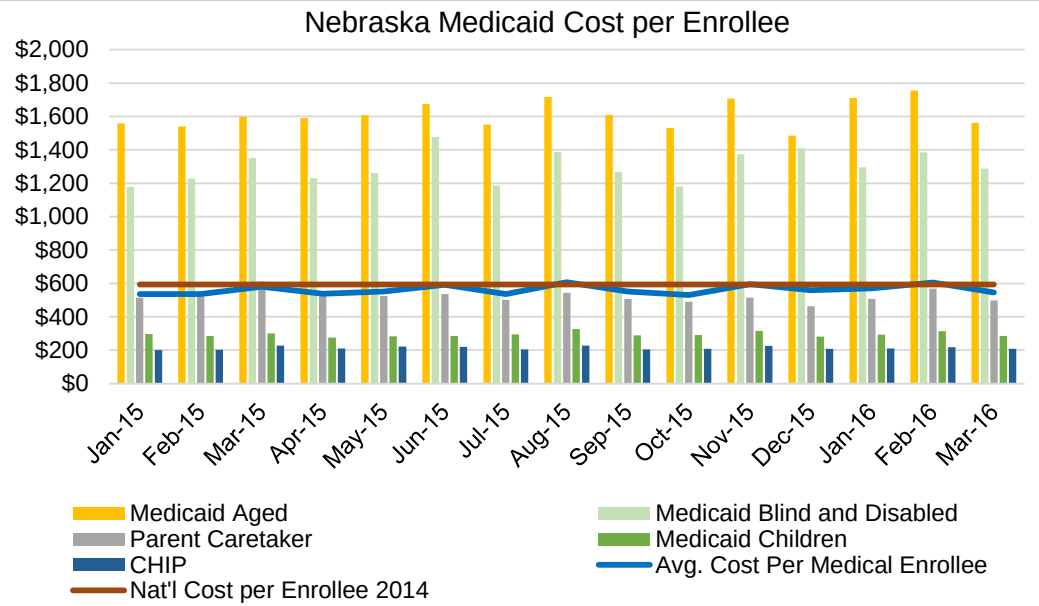
Nebraska Medicaid Enrollment



Nebraska Medicaid Cost Avoidance

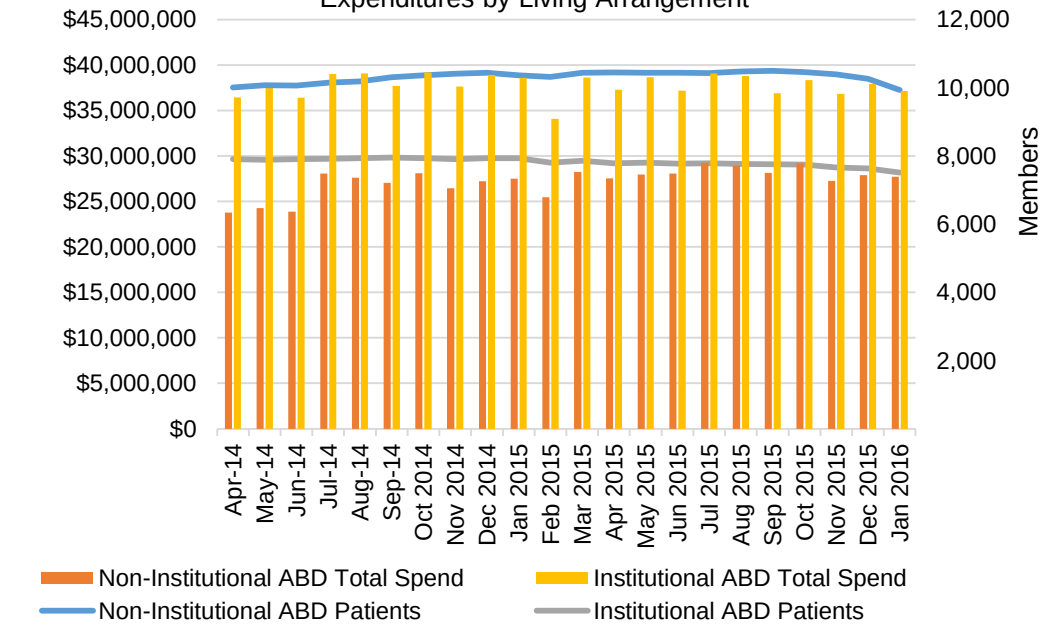


Nebraska Medicaid Cost per Enrollee



*Average Cost Per Medicaid Enrollee is the cost per capita of all Nebraska Medicaid Enrollees.
*National Consumption Expenditures excludes figures for Government Public Health Activities.
*Source: CMS.gov NHE Fact Tables, Accessed 6/15

Nebraska Medicaid Aged, Blind, and Disabled Members and Long Term Services Expenditures by Living Arrangement



Medicaid Dashboard Talking Points

Nebraska Medicaid Aged, Blind, and Disabled Long Term Services Expenditures by Living Arrangement

- Total spend and number of patience in each category has held steady in recent months.
- This chart depicts total cost of long-term services for Aged, Blind, and Disabled Nebraska Medicaid members.
- The intent of this chart is to compare change over time of categorical costs and population changes.
- The figures are broken out by institutional and non-institutional living arrangements.
- Enrollee categories are exclusive from one another.

Nebraska Medicaid Neonatal Intensive Care Unit (NICU) Patients and Average Days per Patient

- This chart depicts the average days covered by Nebraska Medicaid for patients within NICUs and number of patients per month. Days are defined as days spent within a Nursery Level IV type of care per UB-04 Data Specification Manual 2016, Version 10.00.
- The intent of this chart is to show trends of average NICU usage and patient coverage by Nebraska Medicaid over time.
- The average of days is based on a 12 month moving average to reduce noise within the data.
- This time frame includes months with reasonable maturity of claims information captured and tabulated.

Nebraska Medicaid Cost per Enrollee

- This chart depicts per member cost of care for Nebraska Medicaid Members.
- The intent of this chart is to compare month to month costs by enrollee category to national benchmarks and over time comparison within the Nebraska Medicaid categories that are commonly used for comparison across the U.S.
- The National figure on this chart is derived from the 2015 National Health Expenditure report published by CMS.gov.
- The time frame includes months with reasonable maturity of claims information captured and tabulated.
- There is currently a data issue which intrinsically deflates these figures by approximately 2% to 4.5%.
- There are efforts in motion to rectify this issue and figures will be updated at the earliest time possible.

Nebraska Medicaid Cost Avoidance

- This chart depicts the dollar amount of claims submitted to Nebraska Medicaid without proper adjudication from the primary payer(s); they are denied and returned to providers with information to submit to the appropriate payer(s)
- The intent of this chart is to depict cost avoidance amounts, monthly and cumulative over time.
- Monthly figures are aligned to the primary Y axis, and annual/cumulative figures are aligned to the secondary Y axis, as noted in the chart.
- Cost avoidance figures are subject to court decisions that will introduce noise to the data set, on intermittent occasions.

Required with Proposal	Description	Due Date
~~Proposed Rule Implementation Plan~~	~~Plan for complying with new CMS Medicaid managed care rules as described in Section IV.C - Business Requirements.~~	~~Required with proposal~~
Provider Contract Template	Submit provider contract template as described in Section IV.I - Provider Network.	Required with proposal
Network Development Plan	Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.	Required with proposal
Key Staff Resumes	As possible, submit resumes of proposed key staff as described in Section IV.X - Transition and Implementation.	Required with proposal
Preliminary Implementation Plan	Submit preliminary implementation plan as described in Section IV.X - Transition and Implementation.	Required with proposal
Draft Member Handbook	Submit a draft copy of the member handbook as described in Section IV.F – Member Services and Education.	Required with proposal
Contract Award Period	**Description**	**Due Date**
Implementation Plan	Submit contract implementation plan as described in Section IV.X - Transition and Implementation.	30 calendar days after contract award
Pharmacy Transition Plan	Submit plan for transitioning from the MLTC FFS program to the MCO pharmacy plan as described in Section IV.X - Transition and Implementation.	30 calendar days after contract award
120 Days Prior to Contract Start Date	**Description**	**Due Date**
Member Handbook	Submit member handbook for approval as described in Section IV.J - Provider Services.	120 days prior to contract start date

Marketing Plan	Submit plan detailing proposed marketing activities and materials as described in Section IV.G - Member Marketing.	120 days prior to contract start date
Welcome Packet Contents	Submit welcome packet materials as described in Section IV.F - Member Services and Education	120 days prior to contract start date
Welcome Call Script	Submit script for member welcome calls as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Member Education Plan	Submit member education plan as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Enrollment Broker	Submit policies and procedures for receiving file submissions from the Enrollment Broker as described in Section IV.B - Eligibility and Enrollment.	120 days prior to contract start date
Quality Administrative Expenses Proposal	Submit proposal for MLTC review and approval for quality activities to be considered as part of the 3% admin cap.	120 days prior to contract start date
90 Days Prior to Contract Start Date	**Description**	**Due Date**
Proposed Rule Implementation Plan	Plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.	90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier).
Provider Network List	Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network.	90 days prior to contract start date
Provider Network Sufficiency Attestation	Submit data and analysis attesting to the sufficiency of the MCOs network as described in Section IV.I - Provider Network.	90 days prior to contract start date
Subcontracts	Submit all subcontracts for the provision of any services for prior review and approval as described in Section IV.K - Subcontracting.	90 days prior to contract start date

MCO Provider Website	As detailed in Section IV.J - Provider Services, the MCO's provider website is considered marketing material and must be submitted for review and approval.	90 days prior to contract start date

Provider Training Handbook and Training Schedule	Submit a copy of the provider training handbook and training schedule as described in Section IV.J - Provider Services	90 days prior to contract start date
Provider Handbook	Submit provider handbook for approval as described in Section IV.J - Provider Services	90 days prior to contract start date
Pharmacy Claims	Submit policies and procedures for pharmacy claims as described in Section IV.S - Claims Management	90 days prior to contract start date
Pharmacy Pricing Rules and Algorithms	Submit pricing rules and algorithms for pharmacy claims as Section IV.S - Claims Management.	90 days prior to contract start date
MAC Pricing	Submit policies and procedures for MAC pricing as described in Section IV.S - Claims Management.	90 days prior to contract start date
Care Management Program	Submit program description, policies and procedures for Care Management as described in Section IV.L - Care Management.	90 days prior to contract start date
Continuity of Care	Submit policies and procedures for continuity of care as described in Section IV.L - Care Management.	90 days prior to contract start date
HCBS Coordination	Submit policies and procedures for coordinating with HCBS case managers as described in Section IV.L - Case Management.	90 days prior to contract start date
Pharmacy Coverage Policies and Procedures	Submit pharmacy coverage policies and procedures as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
Extemporaneously Compound Drugs	Submit policies for extemporaneously compound drugs as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
Formulary	Submit formulary for review as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date

OTC Drug List	Submit list of covered OTC drugs as described in Section IV.E - Covered Services and Benefits.	90 days prior to contract start date
60 Days Prior to Contract Start Date	**Description**	**Due Date**
QAPI Committee Description	Submit a description and detail the composition of the QAPI Committee (QAPIC) as described in Section IV.M - Quality Management.	60 days prior to contract start date
QM Program Description and Goals	Submit overview of QM program as described in Section IV.M - Quality Management	60 days prior to contract start date
Remedial Action Policy and Procedures	Submit procedures for remedial action to address deficiencies as described in Section IV.M - Quality Management.	60 days prior to contract start date
Corrective Action Triggers	Submit description of deficiencies that require corrective action as described in Section IV.M - Quality Management.	60 days prior to contract start date
Corrective Action Monitoring	Submit policies and procedures for evaluating corrective actions.	60 days prior to contract start date
Provider Review	Submit procedures for provider review.	60 days prior to contract start date
SHCN Care Quality Assessment	Submit procedures for assessing the quality and appropriateness of care furnished to members with SHCNs.	60 days prior to contract start date
Clinical Advisory Committee	Submit plan for the development of the Clinical Advisory Committee as described in Section IV.M - Quality Management.	60 days prior to contract start date
Member Advisory Committee	Submit plan for the development of the Member Advisory Committee including meetings schedule and objectives s described in Section IV.M - Quality Management.	60 days prior to contract start date

Tribal Members Coordination	Submit policies and procedures for coordination and collaboration with qualified members as described in Section IV.L - Care Management.	60 days prior to contract start date
Coordination with Division of Family Services	Submit policies and procedures for coordinating with the DHHS Division of Children and Family Services as described in Section IV.L - Care Management.	60 days prior to contract start date
Health Risk Assessment Algorithms and Methodologies	Submit proposed methodology and algorithms for health risk assessment as described in Section IV.L - Care Management.	60 days prior to contract start date
PBM Independence Assurance	Submit procedures and assurances regarding PBM independence as described in Section IV.L - Care Management.	60 days prior to contract start date
PBM Oversight Plan	Submit plan for monitoring PBM performance as described in Section IV.S - Claims Management.	60 days prior to contract start date
Claims Dispute Process	Submit policies and procedures for addressing claims disputes as described in Section IV.S - Claims Management.	60 days prior to contract start date
Physician Incentive Plan Contract Templates	Submit contract templates for Physician Incentive Plan participants as described in Section IV.Q - Provider Reimbursement.	60 days prior to contract start date
Service Authorization	Submit policies and procedures for service authorization as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Retrospective UR Functions	Submit policies for retrospective UR functions as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Utilization Management Program Description	Submit UM program description as described in Section IV.N - Utilization Management.	60 days prior to contract start date

Drug Utilization Review Program Guidelines	Submit guidelines for DUR program as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Clinical Criteria for Drug Prior Authorization	Submit criteria for drug prior authorization as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Grievances and Appeals	Submit policies and procedures for the handling of member/provider grievances and appeals as described in Section IV.H - Grievances and Appeals.	60 days prior to contract start date
45 Days Prior to Contract Start Date	**Description**	**Due Date**
Amount, Duration, and Scope Policies	Submit amount, duration and scope policies as described in Section IV.E - Covered Services and Benefits.	45 days prior to contract start date
Lab Services Authorization Policies	Submit policies for lab services authorization as described in Section IV.E - Covered Services and Benefits.	45 days prior to contract start date
Value-Added Services	Provide a description of the expanded services/benefits the MCO will provided as described in Section IV.E - Covered Services and Benefits	45 days prior to contract start date
Provider Complaint System	Submit policies and procedures detailing the MCO's provider complaint system as described in Section IV.J - Provider Services.	45 days prior to contract start date
Provider Directory Template	Submit templates for the provider directory as described in Section IV.E - Members Services and Education.	45 days prior to contract start date
Human Resources and Staffing Plan	Submit a plan detailing how the MCO will obtain and maintain appropriate staffing levels as described in Section IV.D - Staffing.	45 days prior to contract start date

Key Staff List	Submit the names, resumes and contact info for all key staff as described in Section IV.D - Staffing	45 days prior to contract start date
Credentialing/Recredentialing	Submit policies and procedures for credentialing and recredentialing providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Provisional Credentialing for Behavioral Health	Submit policies and procedures for the provisional credentialing of behavioral health providers.	45 days prior to contract start date
Network - Communication of Change	Submit procedures for communicating contractual and/or program changes to providers.	45 days prior to contract start date
Network Compliance	Submit procedures for ensuring provider compliance with State and MCO policies as described in Section IV.I - Provider Network.	45 days prior to contract start date
Network Service	Submit procedures for evaluating the quality of services provided by the network.	45 days prior to contract start date
Network Insufficiency	Submit policies and procedures for arranging for medically necessary services in the event of temporary network insufficiency as described in Section IV.I - Provider Network.	45 days prior to contract start date
Network Monitoring	Submit procedures for monitoring the adequacy, accessibility and availability of network providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Specialty Drug List	Submit list of specialty drugs as described in Section IV.I - Provider Network.	45 days prior to contract start date
Compliance Plan	Submit fraud, waste, abuse and erroneous payments compliance plan as described in Section IV.O - Program Integrity.	45 days prior to contract start date

Fraud, Waste, Abuse and Erroneous Payments	Submit fraud, waste, abuse and erroneous payments policies as described in Section IV.O - Program Integrity.	45 days prior to contract start date
Advance Directives	Submit policies and procedures for Advance Directives as described in Section IV.F - Member Services and Education	45 days prior to contract start date
Timely Access	Submit policies and procedures for the monitoring of timely access requirements as described in Attachment 2 - Access Standards.	45 days prior to contract start date
Selection and Retention of Providers	Submit policies for the selection and retention of providers as described in Section IV.I - Provider Network.	45 days prior to contract start date
Member Privacy	Submit policies and procedures for protecting member privacy	45 days prior to contract start date
PCP Assignment	Submit policies and procedures for PCP assignment as described in Section IV.B - Eligibility and Enrollment.	45 days prior to contract start date
Second Opinions	Submit policies and procedures regarding ensuring member access to a second opinion.	45 days prior to contract start date
Restricted Services	Submit policies and procedures for restricted services as described in Section IV.N - Utilization Management	45 days prior to contract start date
30 Days Prior to Contract Start Date	**Description**	**Due Date**
Subcontractor Evaluation	Submit copies of subcontractor evaluations as described in Section IV.C - Business Requirements.	30 days prior to contract start date
Third Party Liability	Submit procedures for identifying TPL and administrating payment as described in Section IV.P - MCO Reimbursement.	30 days prior to contract start date

Provider Preventable Conditions	Submit procedures for precluding payment to providers for provider preventable conditions as required in Section IV.P - Provider Reimbursement.	30 days prior to contract start date
Clinical Practice Guidelines	Submit clinical practice guidelines developed in accordance with requirements in Section IV.N - Utilization Management.	30 days prior to contract start date
Emergency Medical and Post-Stabilization Services.	Submit policies and procedures for emergency medical and post-stabilization services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Family Planning Services	Submit policies and procedures for family planning services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Indian Health Protections	Submit policies and procedures for Indian health protections as described in Section IV.F - Members Services and Education.	30 days prior to contract start date
Direct Access to Women's Health Specialists	Submit policies and procedures for guaranteeing female members direct access to women's health specialists as described in Section IV.I - Provider Network.	30 days prior to contract start date
EPSDT Services	Submit policies and procedures for EPSDT services as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Staffing	Submit policies and procedures for staffing as described in Section IV.D - Staffing.	30 days prior to contract start date
Maintenance of Medical Records	Submit policies and procedures for the maintenance of medical records as described in Section IV.E - Member Services and Education.	30 days prior to contract start date

Medical Record Confidentiality	Submit policies and procedures regarding maintaining the confidentiality of member medical records.	30 days prior to contract start date
Transportation	Submit policies for transportation as described in Section IV.E - Covered Services and Benefits.	30 days prior to contract start date
Dual Eligibles	Submit policies and procedures for addressing needs of dual eligible members.	30 days prior to contract start date
Member Calls	Submit policies and procedures for managing member calls as described in Section IV.F - Member Services and Education.	30 days prior to contract start date
Referrals	Submit policies and procedures on referrals for specialty care and other benefits not provided by the member's PCP.	30 days prior to contract start date
Brand Name Products	Submit policies and procedures for brand name products as described in Section IV.Q - Provider Reimbursement.	30 days prior to contract start date
After Contract Start Date	**Description**	**Due Date**
PCMH Implementation Plan	Submit plan for PCMH implementation as described in Section IV.I - Provider Network.	90 days after contract start date
Value-Based Contracting Plan	Submit plan for implementing value-based purchasing agreements as described in Section IV.Q - Provider Reimbursement.	Due by December 17, 2017

c. How medical information will be updated and appropriately shared, which may include the development and implementation of an electronic health record.

d. Steps to ensure continuity of health care services.

e. The oversight of prescription medications.

M. QUALITY MANAGEMENT

1. The MCO must include QM processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members.

a. The MCO's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract.

b. The MCO must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system as a result of this RFP. The MCO will be provided with the final Quality Strategy when it is approved by CMS.

c. The MCO must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities.

d. The MCO's QM program must include:

i. A quality assurance and performance improvement (QAPI) program.

ii. Performance improvement projects (PIPs).

iii. Quality performance measurement and evaluation.

iv. Member and provider surveys.

v. MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program, as described in Sections IV.C Business Requirements and IV.I Provider Network Requirements of this RFP.

e. The MCO must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as UM and CM. The MCO is expected to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization.

2. Quality Management Deliverables

The MCO must submit the following QM deliverables to MLTC as described in Attachment 5 – Policies, Procedures and Plans, and ~~Attachment 6 – Reporting Requirements~~ Attachment 38 – Revised Reporting Requirements. Any subsequently revised documents must also be submitted to MLTC for review and approval a minimum of 60 calendar days prior to their planned implementation.

a. Description and composition of the QAPI Committee (QAPIC).

b. A written description of the MCO's QM program, including detailed QM goals and objectives, a definition of the scope of the program, accountabilities, and timeframes.

c. A QM work plan and timeline for the coming year that clearly identifies target dates for implementation and completion of all phases of the MCO's QM activities, consistent with the clinical quality performance measures and targets set by MLTC, including, but not limited to:

i. Data collection and analysis.

ii. Evaluation and reporting of findings.

iii. Implementation of improvement actions, where applicable.

iv. Individual accountability for each activity.

d. Procedures for remedial action for deficiencies that are identified.

e. Specific types of problems requiring corrective action.

f. Provisions for monitoring and evaluating the corrective actions to ensure that improvement actions have been effective.

g. Procedures for provider review and feedback about results.

h. Annual QM evaluation that includes:

i. Description of completed and ongoing QM activities.

ii. Identified issues, including tracking of issues over time.

iii. Analysis of and tracking progress about implementation of QM goals and the principles of care, as appropriate, and as defined in this RFP. Measurement of and compliance with these principles must be promoted and enforced through the following strategies, at a minimum:

a) Use of QM findings to improve practices at the MCO and subcontractor levels.

b) Timely reporting of findings and improvement actions taken and their relative effectiveness.

c) Dissemination of findings and improvement actions taken and their relative effectiveness to key stakeholders, committees, members, families/caregivers (as appropriate), and posting on the MCO's website.

d) Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. The MCO must use an industry-recognized methodology, such as SIX SIGMA or other appropriate method(s), for analyzing data. The MCO must demonstrate inter-rater reliability testing of evaluation, assessment, and UM decisions.

e) An analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program.

i. Procedures assessing the quality and appropriateness of care furnished to members with SHCNs. The assessment mechanism must use appropriate health care professionals to determine the quality and appropriateness of care.

3. QAPI Program

The MCO's QAPI program, at a minimum, must comply with State and Federal requirements (including 42 CRF 438.204) and UM program requirements described in 42 CFR 456. The QAPI program must:

a. Ensure continuous evaluation of the MCO's operations. The MCO must be able to incorporate relevant variables as defined by MLTC.

b. At a minimum, assess the quality and appropriateness of care furnished to members.

c. Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.

d. Maintain a health information system that can support the QAPI program. The MCO's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by the State's Quality Strategy. All collected data must be available to the MCO and MLTC.

e. Make available to its members and providers information about the QAPI program and a report on the MCO's progress in meeting its goals annually. This information must be submitted for review and approval by MLTC prior to distribution.

f. Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance. The MCO must further develop, operationalize, and implement the outcome and quality performance measures with the QAPIC, with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.

g. Require that the MCO make available records and other documentation, and ensure subcontractors' participation in and cooperation with, the annual on-site operational review of the MCO and any additional QM reviews. This may include participation in staff interviews and facilitation of member/family/caregiver, provider, and subcontractor interviews.

4. QAPIC

a. The MCO must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

b. The MCO must form a QAPIC no later than one month following the contract's start date. The MCO's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.

c. The MCO must include, at a minimum, the following as members of the committee:

i. The MCO's QM Coordinator.

ii. The MCO's Performance and Quality Improvement Coordinator.

iii. The MCO's Medical Management Coordinator.

iv. The MCO's Member Services Manager.

v. The MCO's Provider Services Manager.

vi. Family members/guardians of children or youth who are Medicaid members.

vii. Adult Medicaid members.

viii. Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

d. The MCO's QAPIC must:

i. Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC.

ii. Review the Cultural Competency Plan.

iii. Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify.

iv. Establish annual performance targets.

v. Review and approve all member and provider surveys prior to their submission to MLTC.

vi. Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries.

vii. Provide training; participation stipends; and reimbursement for travel, child care, or other reasonable participation costs for members or their family members. Participation stipends should only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization.

viii. Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.

e. Additional required committees must include:

i. Clinical Advisory Committee.

ii. Corporate Compliance Committee.

iii. Provider Advisory Committee.

iv. Utilization Management Committee.

v. The additional required committees must report, on a minimum of a quarterly basis, to the QAPIC. The QAPIC must monitor performance as part of its annual QAPI Work Plan and Program Evaluation.

5. Data Collection

a. The MCO must collect performance data and conduct data analysis with the goal of improving members' quality of care. The MCO must document and report to the State its results on performance measures chosen by MLTC to improve quality of care and members' health outcomes.

b. Data analysis must consider the MCO's previous year's performance, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. Data must be collected from administrative systems, medical records, and member and provider surveys. The MCO must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the MCO's encounter data system. The MCO must ensure that data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data.

ii. Screening the data for completeness, logicalness, and consistency.

iii. Collecting service information using MLTC-developed templates.

c. The MCO's data analysis process must be able to identify and resolve system issues consistent with a continuous quality improvement approach.

d. The MCO is responsible for collecting valid and reliable data and using qualified staff to report it. Data collected for performance measures and PIPs must be returned by the MCO in a format specified by MLTC, and by the due date specified. Any extension to collect and report data must be made in writing in advance of the initial due date and is subject to approval by MLTC. Failure to follow the data collection and reporting instructions that accompany the data request may result in a penalty being imposed on the MCO per Section IV, V Contract Non-compliance.

6. Quality Performance Measurement and Evaluation

a. The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Healthcare

Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS (Section 2701 of the ACA), and any other measures as determined by MLTC.

b. MLTC may utilize a hybrid or other methodology for collecting and reporting performance measure rates, as allowed by NCQA for HEDIS measures or as allowed by other entities for nationally recognized measures. The MCO must collect data from medical records, electronic records, or through approved processes, such as those utilizing a health information exchange. The number of records that the MCO collects will be based on HEDIS, external quality review (EQR), or other sampling guidelines. It may also be affected by the MCO's previous performance rate for the measure being collected. The MCO must provide MLTC on request with its methodology for calculating performance measures.

c. The MCO must show demonstrable and sustained improvement toward meeting MLTC performance targets. MLTC may impose sanctions on an MCO that does not show statistically significant improvement in a measure rate. MLTC may require the MCO to demonstrate that it is allocating increased administrative resources to improve its rate for a particular measure. MLTC also may require a corrective action plan and may sanction any MCO that shows a statistically significant decrease in its rate, even if it meets or exceeds the minimum standard.

d. The MCO must report results of measuring or assessing outcomes and quality, and must incorporate these performance indicators into its PIPs. To the extent possible, results should be posted publicly on the MCO's website immediately after being accepted by the QAPI Committee and approved by MLTC.

e. Any outcomes and performance measure results that are based on a sample of member, family, or provider populations must demonstrate that the samples are representative and statistically valid. Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks.

f. The MCO must report to MLTC on a quarterly basis the minutes and disposition of quality program initiatives that were presented to the QAPIC to ensure that all quality initiatives are reviewed at the frequencies outlined in the Quality Management Program Description. The reporting requirements are described in ~~Attachment 6 – Reporting Requirements~~ Attachment 38 – Revised Reporting Requirements.

7. Performance Improvement Projects

a. The MCO must conduct a minimum of two clinical and one non-clinical PIPs. A minimum of one (1) clinical issue must address an issue of concern to the MCO's population, which is expected to have a favorable effect on health outcomes and enrollee satisfaction. A second clinical PIP must address a behavioral health concern. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.

b. The MCO must participate in a minimum of one (1) joint PIP with the other MCOs; the topic will be identified by MLTC.

c. PIPs must be addressed in the MCO's annual QM Program Description, Work Plan, and Program Evaluation. The MCO must report the status and results of each project to MLTC as outlined in the Quality Strategy. PIPs must comply with CMS requirements, including:

i. A clear study topic and question as determined or approved by MLTC.

ii. Clear, defined, and measurable goals and objectives that the MCO can achieve in each year of the project.

iii. A study population.

iv. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use

measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

v. The methodology for evaluation of findings from data collection.

vi. Implementation of system interventions to achieve quality improvement.

vii. A methodology for the evaluation of the effectiveness of the chosen interventions.

viii. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable.

ix. Planning and initiation of activities for increasing and sustaining improvement.

d. 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.

e. The MCO must implement the PIP recommendations on approval by MLTC and the QAPIC.

f. Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the MCO's quality assessment and performance improvement program [42 CFR 438.240(d)(2)].

g. CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the MCO.

h. MLTC reserves the right to request additional reports from the MCO. The MCO will be notified of additional reporting requirements no less than 30 calendar days prior to the due date of a report.

8. Member Satisfaction Surveys

a. The MCO must contract with a vendor that is certified by NCQA to perform CAHPS surveys, including CAHPS Adult surveys and CAHPS Child surveys with children with chronic conditions (CCC) supplemental items.

b. The MCO must use the most current version of CAHPS for Medicaid enrollees. For the CAHPS Child Surveys with CCC supplemental items, the MCO must separately sample the Title XIX (Medicaid) and Title XXI (CHIP) populations and separate data and results when submitting reports to MLTC to fulfill the CHIPRA requirement.

c. Samples of members 18 years of age and older and caregivers/family members of children and youth should be included in all member surveys. Samples should be representative of members and caregivers/family members based on the type of question asked.

d. Each survey must be administered to a statistically valid random sample of members who are enrolled in the MCO at the time of the survey. Analyses must include statistical analysis for targeting improvement efforts and comparison to national and State benchmark standards. Survey results and action plans derived from these results are due 45 calendar days after the end of each contract year. MLTC reserves the right to make CAHPS member survey results public.

e. Survey results and descriptions of the survey process must be reported to MLTC separately for each required CAHPS survey. Upon administration of the CAHPS Child surveys, results for Medicaid children and CHIP children must be reported separately.

9. Provider Satisfaction Surveys

a. The MCO must conduct an annual provider survey to assess providers' satisfaction with provider credentialing, service authorization, MCO staff courtesy and professionalism, network management, appeals, referral assistance, coordination, perceived administrative burden, provider communication, provider education, provider complaints, claims reimbursement, and utilization management processes, including medical reviews and support for PCMH implementation.

b. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the MCO 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 a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

c. The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results. This report is due 45 calendar days after the end of the each contract year.

10. MLTC Quality Management Committee

The MCO must attend annual meetings of MLTC's QM Committee. The QM Committee meets to review data and information used to develop the Quality Strategy; recommend actions to improve members' quality of care, access, utilization, and satisfaction; and, to review the PIP results and recommend future PIP topics. The QM Committee also reviews MLTC's Quality Strategy and makes recommendations for its improvement.

11. Member Advisory Committee

a. To promote a collaborative effort to enhance the MCO's patient-centered service delivery system, the MCO must establish a Member Advisory Committee that is accountable to the MCO's governing body. Its purpose is to provide input and advice regarding the MCO's program and policies.

b. The MCO's Member Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO's membership.

c. At a minimum, the MCO's Member Advisory Committee must provide input into the MCO's planning and delivery of services; QM/quality improvement activities; program monitoring and evaluation; and, member, family, and provider education.

d. The MCO must provide an orientation and ongoing training for Member Advisory Committee members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities.

e. The MCO must develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the Committee that must include, but is not limited to, members' perspectives about improving quality of care. This Plan must be submitted to MLTC for approval a minimum of 60 calendar days before the contract start date and annually thereafter.

f. The MCO's Member Advisory Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are members or their representatives.

g. MLTC must be copied on all correspondence to the committee, including agendas and committee minutes.

h. The MCO must report on the activities of the MCO's Member Advisory Committee semi-annually. This report must include the membership of the committee (name, address, and organization represented), a description of any orientation and/or ongoing training activities for committee members, and information about Committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports must be submitted to MLTC according to the schedule described in ~~Attachment 6 – Reporting Requirements~~ Attachment 38 – Revised Reporting Requirements.

12. Clinical Advisory Committee

a. The MCO must develop, establish, and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of treatment, including diseases/chronic conditions common in the Medicaid population, disabilities, and mental health and/or substance use disorder treatment for adults, children, and adolescents in the State.

b. The Clinical Advisory Committee must provide input into all policies, procedures, and practices associated with CM and utilization management functions, including clinical and practice guidelines, and utilization management criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State.

c. The committee must include members who care for children, adolescents and adults in the State across a variety of ages and races/ethnicities, have an awareness of differences between rural and urban populations and represent pharmacists, physical health providers, and behavioral health providers.

d. The committee must review and approve initial practice guidelines. Any significant changes in guidelines must also be reviewed/approved by the Committee prior to adoption by the MCO.

e. The committee must meet on an as-needed basis, but a minimum of twice a year and preferably quarterly.

f. The MCO must submit to MLTC for approval its plan for development of the committee a minimum of 60 calendar days in advance of its establishment. The MCO must also provide copies of the committee's minutes to MLTC.

13. External Quality Review

a. The MCO is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR 438.350. The EQR is conducted by MLTC's contracted external quality review organization (EQRO) or other designee. The EQR will include, but is not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.

b. The MCO must provide the necessary information required for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.

N. UTILIZATION MANAGEMENT

1. General Requirements

a. The MCO's UM activities must include the evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them. The MCO's UM program must also focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services.

b. The MCO's UM program must comply with Federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 438.

c. The MCO must require inpatient hospital providers to comply with Federal requirements regarding UM plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 CFR 44, 455 and 456.

d. The MCO must not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member, as described in 42 CFR 210(e).

e. The MCO must actively monitor Federal and State Medicaid regulations for updates and changes and must monitor all UM activities for compliance with Federal and State Medicaid regulations.

Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day. All reports must be submitted in an MLTC provided template or in a format approved by MLTC.

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third Party Resource	All instances in which a TPR was identified for a member as described in Section IV.P - MCO Reimbursement.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	15th day of the following calendar month
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month

All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the MCO	Summary of all referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the MCO Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Pharmacy Prior Authorizations	Prior authorizations summary, including clinical and technical prior authorizations, peer review, and peer to peer consultation statistics.	15th day of the following calendar month
Pharmacy Technical and Clinical Call Center	Performance summary for call center metrics, pharmacy services, prior authorization request turnaround time, and training issues.	15th day of the following calendar month
Pharmacy Claims Processing	Summary data and analysis on pharmacy claims processing including: generic analysis (will be detailed by MLTC), MAC priced medications, claims adjudication system availability and payment statistics, number of prescriptions dispensed by public retail pharmacies (mail order pharmacies and specialty pharmacies included but delineated), total members utilizing pharmacy claims system, and total membership.	15th day of the following calendar month
Psychotropic Medications for Youth	Summary of prior authorization and utilization relating to clinical edits.	15th day of the following calendar month
PDL Load	Data documenting that the PDL file was received and loaded weekly.	15th day of the following calendar month
Behavioral Health Residential Wait List	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	15th day of the following calendar month
Out of State Placement	Summary data of the number of members placed in out of state residential treatment.	15th day of the following calendar month
Eligible and Number Authorized	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	15th day of the following calendar month

Welcome Calls	Results of welcome calls to new members as described in Section IV.F - Members Services and Education.	15th day of the following calendar month
Hospice	Data summarizing hospice admissions.	15th day of the following calendar month
Medically Necessary State Wards in Residential Treatment	Data summarizing the number of state wards deemed "medically necessary" who are in residential treatment.	15th day of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing MCO member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Quarterly Deliverables	**Description**	**Due Date**
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter

Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Drug Utilization Management Retrospective Educational Intervention Project	Project update in a format approved by MLTC.	45 calendar days following the most recent quarter
Prospective DUR Statistics	DUR statistics to support preparation of MLTC's annual CMS DUR report.	45 calendar days following the most recent quarter
Pharmacy Financial Report	Summary data on committed pharmacy dollars, pharmacy total claims dollars, MCO supplemental rebate dollars, and MAC savings.	45 calendar days following the most recent quarter
Pharmacy Utilization Management	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	45 calendar days following the most recent quarter
PDL Compliance	Data documenting accuracy in dispensing medications in PDL categories.	45 calendar days following the most recent quarter
Care Management Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	45 calendar days following the most recent quarter

Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Network PCP Access	Summary data and metrics on PCP access as determined by MLTC and described in Attachment 2 - Access Standards.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Quality Oversight Committee	Committee activity summary as described in Section IV.M - Quality Management.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management - Authorization	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter

Utilization Management - Claims	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	45 calendar days following the most recent quarter
Contracted Residential Beds	Summary data on the number of behavioral health-related residential beds available state-wide.	45 calendar days following the most recent quarter
Critical Incident Reporting	Summary data on the number of critical incident reports by behavioral health facility and location.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
30 day Ambulatory/Inpatient Readmission Rates	Summary data on the number of individuals readmitted to the emergency room 30 or more days post the prior admission.	45 calendar days following the most recent quarter
7 and 30 Day Ambulatory Follow-up Following Residential Discharge	Summary data on the number of individuals presenting to the emergency room 30 days after discharge from Acute Psych or SUD.	45 calendar days following the most recent quarter
Admissions and Readmits to Psych Inpatient	Data summarizing the number of admissions and readmits to psych inpatient, including Psychiatric Residential Treatment Facilities and Therapeutic Group Homes.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the MCO and MLTC.	45 calendar days following the most recent quarter

Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Medication Therapy Management	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter
Top Ten Diagnoses by Service Category	Data summarizing the top ten diagnoses by service category.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Quality Management Program Description and Work Plan	Discussion of the MCO's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the contract year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the contract year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	30 calendar days following the 12th month of the contract year

Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the contract year
Direct Medical Education/Indirect Medical Education Verification	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Due date to be provided prior to contract start
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the contract year
HEDIS Report	HEDIS results.	June 30
CHIPRA Quality Measures	CHIPRA performance measure results.	45 calendar days following the 12th month of the contract year
Adult Core Measures	Adult Core Measures results.	45 calendar days following the 12th month of the contract year
Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	30 calendar days following the 12th month of the contract year
Facility Satisfaction Survey	Data and analysis summarizing results of the annual facility provider satisfaction survey.	30 calendar days following the 12th month of the contract year
Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the contract year

Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the contract year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	June 1
Network Development Plan	Details of the MCO's network, including GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	November 1
Utilization Management Program Review	Data and analysis summarizing the MCO's annual evaluation of its UM program.	30 calendar days following the 12th month of the contract year
Legislative Reports	**Description**	**Due Date**
LB 1063 - Children's Health and Treatment Act	Data and Geo Access reports related to youth Medicaid mental health authorization requests (all children ages 0-19) and Medicaid mental health authorization requests (all age groups reported by ages 0-18 years, 19-64 years, and 65+ years)	Quarterly reports submitted to Nebraska Legislature on January 1, April 1, July 1, and October 1 by MLTC.
LB 1160 Legislative Report	Number of state wards receiving behavioral health services as of September 1 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Upon DHHS request.

Attachment 4
Patient-Centered Medical Home Standards

Core Competency 1: Facilitate ongoing patient relationship with ~~physician in a physician-directed team.~~ a primary care practice team.

1. Practice utilizes written plan for patient communication including accommodations for those with difficulty seeing or hearing and English as a second language patients.
2. Practice utilizes written materials for patients that explain the features and essential information related to the medical home; materials are published in primary language(s) of the community.
3. Practice utilizes patient-centered care planning (includes patient's goals, values, and priorities) to engage patients in their care. Practice plan can include a written after visit summary outlining future care plan and given to patient at every visit.
4. Practice utilizes reminder/notification system for health care services such as appointments, preventive care, preparation information for upcoming visits, follow-up with patients regarding periodic tests or screening, and for missed appointments.
5. Practice provides patient education and self-management tools and support for patients, families, and caregivers.
6. ~~Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.~~ Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care provider(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
7. Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

Core Competency 2: **Coordinate continuous patient-centered care across the health care system.**

1. Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2. Practice provides care coordination and supports family participation in care including providing connections to community resources.
3. Practice utilizes a system to maintain and review a list of patient's medications.
4. Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient, plus follows up after referrals, specialist care, and other consultations.

5. Practice utilizes a patient registry.

6. Practice team defines and identifies high-risk patients in the practice who will benefit from care planning and provides a care plan to these individuals.

7. Practice team provides and coordinates Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

8. Practice team provides transitional care plan for patients transferring to another physician or medical provider.

9. Clinical data is organized in a paper or electronic format for each individual patient.

10. Practice utilizes a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the medical home.

1. Patient has on-call access to the medical home team 24 hours/day, 7 days/week.

2. Practice offers appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.

3. Practice utilizes a system to respond promptly to prescription refill requests and other patient inquiries.

4. Practice provides day-of-call appointments.

5. Practice utilizes written practice standards for patient access.

Core Competency 4: Foster efficiency of care by reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services.

1. Practice implements interventions to reduce unnecessary care or preventable utilization that increases cost without improving health.

2. Practice establishes at least 2 out of 3 of the following waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

1. Practice has established a quality improvement team that, at a minimum, includes one or more clinicians who deliver services within the medical home;

one or more care coordinators; one or more patient representatives; and if a clinic, one or more representatives from administration/management.

2. Practice develops a formal plan to measure effectiveness of care management.

3. Practice develops an operational quality improvement plan for the practice with at least one focus area.

4. Practice utilizes a patient survey to assess their experience of care and sets a schedule for utilization (may be developed or provided by the MCO).

5. Practice identifies one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

Attachment 15
Medical Loss Ratio Requirements

MCOs that receive capitation payments to provide covered services to Nebraska Medicaid members are required to rebate a portion of the capitation payments to MLTC in the event the MCO does not meet the 85% MLR standard. This document describes the methodology for calculating the MLR and payment of any rebate due MLTC.

MLR Calculation

1. A MCO's MLR is the ratio of net qualified medical expenses to qualifying revenue for the MLR calculation:

   MLR = net qualified medical expenses ÷ qualifying revenue for the MLR calculation

2. Net qualified medical expense, the numerator in the MLR calculation, is defined as the sum of:

   a. Claims incurred
   b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
   c. Medical incentive bonuses
   d. Reinsurance premiums less reinsurance recoveries
   e. Activities that improve health care quality, per 45 CFR 158.150
   f. Less related-party medical margin

3. The denominator for the MLR calculation is the aggregate of revenue earned by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignores federal and state premium taxes and non-operating income. Any earned holdback is not factored into the calculation.

4. An activity that improves health care quality can be included in the numerator as long as it meets one of three standards: 1) meets the definition in 45 CFR 158.150 of an activity that improves health care quality and is not excluded under 45 CFR 158.150; 2) is an activity specific to Medicaid managed care external quality review activities; or 3) is an activity related to health information technology and meaningful use, as defined in 45 CFR 158.151, and excludes any costs that are identified as excluded under 45 CFR 158.150 or other federal regulations.

5. The MLR will be calculated using the MCO's "run rate" income statements (not "booked"). "Run rate" is incurred expenses and qualifying revenue for the MLR calculation attributable to activities in the specified contract year.

6. MLTC reserves the right to audit, request additional information, and revise the MCO's estimates of its MLR calculation.

MLR Rebate

1. The MCO must calculate the MLR and submit it to MLTC quarterly. MLTC will calculate the MLR settlement annually, between six and nine months after the end of the contract year.

2. For each reporting year in which the MLR is less than 85%, the MCO must provide a rebate to MLTC per the following formula:

   MLR rebate = maximum of $0 and [(85% - MLR) x qualifying revenue for the MLR calculation]

l) Using the Medicaid member's or another person's information that is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a State or Federal confidentiality law, including:

1) Medical records information.

2) Information that identifies the member as a recipient of any government-sponsored or mandated health coverage program.

m) Using any device or artifice in advertising a MCO or soliciting Medicaid enrollees that misrepresents the solicitor's profession, status, affiliation, or mission.

iii. If MLTC determines that the MCO or its subcontractor(s) has marketed to and the member has enrolled in the MCO, MLTC may impose the following sanctions:

a) The MCO will be required to send a letter to each member, notifying the member of the violation and of his/her right to select another MCO. The members disenrollment will be on the earliest effective date allowed.

b) Any payments made to the MCO on behalf of the member(s) will be recouped if the member disenrolls.

c) The MCO will be assessed an additional $5,000 monetary sanction per member.

iv. If MLTC determines that the MCO has violated any of the marketing and/or outreach requirements outlined in the contract, the MCO may be subject to damages up to $10,000 per violation. The amount of damages is at the discretion of MLTC.

h. Other Liquidated Damages may be assessed as otherwise permitted in the RFP.

i. MLTC will provide written notice and factual basis for the assessment of liquidated damages to the MCO. Within ten (10) business days of receipt of the written notice, the MCO may appeal the assessment of liquidated damages in writing to the Deputy Director of the Delivery Systems Section of MLTC. A written decision will be issues within ten (10) business days. Within five (5) business days of receipt of the written decision, the MCO may request reconsideration of the decision in writing to the Director of MLTC. The Director shall issue a written opinion within 30 calendar days. No further appeals shall be allowed.

3. Failure to Provide Benefits and Services

If MLTC determines that the MCO has failed to provide one or more benefits or services, MLTC will direct the MCO to provide the benefit(s) or service(s). If the MCO continues to refuse to provide the benefit(s) or service(s), MLTC will authorize the member(s) to obtain the services from another source and will notify the MCO in writing that the MCO will be charged the actual cost of the services. In this event, funds equivalent to the expense(s) will be deducted from the next monthly capitation payment or a future payment as determined by MLTC. With the deductions, when made, MLTC will provide a list of the affected member(s) concerning which payments to the MCO have been deducted, the nature of the benefit(s) or service(s) denied, and payments MLTC made or will make to provide the medically necessary covered benefit(s) or service(s).

W. INTERMEDIATE SANCTIONS

1. Acts or Failures to Act Subject to Intermediate Sanctions

The following violations are grounds for intermediate sanctions that may be imposed in the sole discretion of MLTC when the MCO act or fails to act:

a. The MCO fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with MLTC, to a member covered under the contract.

b. The MCO imposes on members premiums or charges that are in excess of allowable charges permitted under the Medicaid program.

c. The MCO discriminates against members on the basis of their health status or need for health care services.

d. The MCO misrepresents or falsifies information that it furnishes to CMS or to the State.

e. The MCO misrepresents or falsifies information that it furnishes to a member, enrollee, or health care provider.

f. The MCO fails to comply with the requirements for physician incentive plans, if applicable.

g. The MCO distributes, directly or indirectly through any agent, marketing materials that were not approved in advance by MLTC or that contain false or materially misleading information.

h. The MCO violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

i. Any other action or inaction that the State deems a violation and that merits a sanction consistent with this section.

2. Other Misconduct Subject to Intermediate Sanctions

MLTC in its sole discretion also may impose sanctions against a MCO if it finds any of the following non-exclusive actions or occurrences:

a. The MCO failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from MLTC.

b. The MCO was excluded from participation in Medicare because of fraudulent or abusive practices, pursuant to Public Law 95-142.

c. The MCO or any of its owners, officers, or directors was convicted of a criminal offense relating to performance of the contract with MLTC, of fraudulent billing practices, or of any negligent practice resulting in death or injury to a MCO member.

d. The MCO presented, or caused to be presented, any false or fraudulent claim for services, or submitted or caused to be submitted false information to the State or CMS.

e. The MCO engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made to the MCO by MLTC.

f. The MCO rebated or accepted a fee or portion of a fee or charge for a member referral.

g. The MCO failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

h. The MCO failed to keep, or make available for inspection, audit, or copying, the records regarding payments claimed for providing services.

i. The MCO failed to furnish any information requested by MLTC regarding payments for providing goods or services.

j. The MCO furnished goods or services to a member, which at the sole discretion of MLTC, and based on competent medical judgment and evaluation, are determined to be insufficient for his/her needs, harmful to the member, or of grossly inferior quality.

3. Sanction Types

a. MLTC may impose the following intermediate sanctions at its sole discretion:

i. Civil monetary penalties as specified in Attachment 18 – Liquidated Damages.

ii. Appointment of temporary management as described in this section.

iii. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.

iv. Suspension of all new enrollments into the MCO, including auto-assignments, as of the effective date of the sanction.

v. Suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

vi. Any other remedy, right, or sanction allowed under the contract or applicable law.

b. Payments under the contract will be denied for new members when, and for as long as, payment for those members is denied by CMS in accordance with the requirements of 42 CFR 438.730.

4. Notice of Sanction to MCO and CMS

a. Prior to imposing any intermediate sanction, the State will give the MCO timely written notice that explains the following:

i. The basis and nature of the sanction.

ii. The MCO's right to an administrative hearing.

b. MLTC will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR 438.700, specifying the affected MCO, the kind of sanction, and the reason for MLTC's decision to lift a sanction (if applicable). Notice will be given no later than 30 calendar days after MLTC imposes or lifts the sanction.

5. Payment of Liquidated Damages and Sanctions

a. The purpose of establishing and imposing liquidated damages is to provide a means for MLTC to obtain the services and level of performance required for successful operation of the contract. MLTC's failure to assess liquidated damages in one or more of the particular instances described herein will in no event waive the right, power, or authority of MLTC to assess additional liquidated damages or actual damages at that time or in the future.

b. The decision to impose liquidated damages (including intermediate sanctions) will include consideration of some or all of the following factors:

i. The duration of the violation.

ii. Whether the violation (or one that is substantially similar) has previously occurred.

ii. The MCO's compliance history.

iii. The severity of the violation and whether it imposes an immediate threat to the health or safety of the MCO's members.

iv. The good faith exercised by the MCO in attempting to achieve or remain in compliance.

c. The violations described in Attachment 18 – Liquidated Damages are examples of the grounds, but not an exclusive list of grounds, on which MLTC may impose liquidated damages.

d. Any liquidated damages assessed by MLTC that cannot be collected through withholding from future capitation payments will be due and payable to MLTC within 30 calendar days after the MCO's receipt of the notice of liquidated damages. However, in the event an appeal by the MCO results in a decision in favor of the MCO, any funds withheld by MLTC will be returned to the MCO as consistent with the appeal decision.

6. Special Rules for Temporary Management

a. MLTC may install temporary management if it finds that there is continued egregious behavior by the MCO, including, but not limited to, behavior that is described in 42 CFR 438.706, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act.

b. MLTC will impose temporary management if it finds that a MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In this circumstance, MLTC must also notify members of the MCO of their right to select another MCO, and allow them to do so. The State may not delay imposition of temporary management to provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

7. Payment of Outstanding Monies or Collections from MCO

The MCO will be paid for any outstanding monies due less any assessed liquidated damages or sanctions. If liquidated damages exceed monies due, collection will be made from the MCO performance bond or any insurance policy or policies required under this contract, as appropriate. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

8. Provider Sanctions

Nothing contained in this RFP shall prohibit MLTC, pursuant to applicable law, from imposing sanctions, including civil liquidated damages, license revocation, and Medicaid termination, on a health care provider for its violations of applicable law.

X. TRANSITION AND IMPLEMENTATION

1. Preliminary Implementation Plan

a. The MCO is responsible for submitting a preliminary implementation plan with its proposal. This plan must describe the MCO's plan to comply with all the major areas of the contract including:

i. Member services.

ii. Network development and management.

iii. Quality management, including credentialing.

iv. Care management.

v. Utilization management.

vi. Transition and care coordination.

vii. Information systems management.

viii. Claims management.

ix. Grievances and appeals.

b. The preliminary implementation plan must also address staffing, facilities, and other operational issues as identified in this RFP and the MCO's proposal. The plan must include tasks, deliverables, and milestones necessary to implement the program.

2. Transition Period

a. The transition period for the contract begins on contract award and ends 90 calendar days after the contract start date. During the transition period the MCO must implement the requirements of the contract and this RFP and collaborate with MLTC to facilitate a seamless transition between MCOs, providers, and programs in order to prevent an interruption of services and to ensure continuity of care for members.

v. Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices.

vi. The Office of Probation.

vii. Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

b. The MCO must collaborate with these entities and programs when serving members and identifying and responding to members' behavioral and physical health needs. It must address and attempt to resolve any coordination of care issues with other MCOs and other State agencies and their contractors, tribes, and other community providers as expeditiously as possible.

c. The MCO must also collaborate with these entities and programs and its network providers regarding planning initiatives and system transformation.

7. Service Orientation, Interoperability, and Data Exchange

The State's Medicaid program is undergoing significant modernization across many projects. In alignment with CMS-MITA guidance, key objectives shared by all MLTC projects include high levels of capability/maturity with respect to service orientation, interoperability, and data exchange. MLTC expects the MCO to transmit and receive data in compliance with all applicable Federal (including but not limited to HIPAA), and State standards and mandates, both currently and in the future. The MCO must work with MLTC to develop and support an effective data exchange between the MCO and all stakeholders involved in the Medicaid program, including MLTC. The MCO shall also provide to MLTC at its request reports via electronic data exchanges to support enhanced analytics and report drill-down capabilities.

8. Participation in the Nebraska Health Information Initiative

The MCO is required to attempt to enter into a participation agreement with the Nebraska Health Information Initiative (NeHII). NeHII is a non-profit organization that includes health care providers, payers, and the State. NeHII's purpose is to achieve health care transformation through the creation of a secure, web-based health information exchange to serve the State. Should the MCO be unable to reach a mutually agreeable arrangement for participation in NeHII within one year of the contract start date, it must notify MLTC.

More information on NeHII can be found at www.nehii.org.

9. Participation in the MLTC Committees

The MCO is required to participate in MLTC committees including, but not limited to, the Administrative Simplification Committee, the Behavioral Health Integration Advisory Committee, and the Quality Assurance Performance Improvement Committee. The Administrative Simplification Committee will include State, MCO, and provider representation, and seek to identify and implement common processes and forms for use by MCOs. The Committee's goal is to reduce administrative burden for MCOs and providers in areas that may include, but not be limited to credentialing/re-credentialing, prior authorization, and grievances and appeals. The Behavioral Health Integration Advisory Committee will include representatives from the DHHS Division of Behavioral Health, MLTC, behavioral health and primary care providers, and MCOs. The Advisory Committee's objective will be to identify and address areas of opportunity or concern regarding the integration of behavioral health and physical health services. A description of the Quality Assurance Performance Improvement Committee is found in Section IV.M Quality Management.

10. Financial Viability/Solvency Requirements

a. Insolvency

The MCO must provide that its Medicaid members are not held liable for:

i. The MCO's debts in the event of the MCO's insolvency.

ii. The cost of covered services provided to the member, for which MLTC does not pay the MCO.

6. Adequate Capacity

When establishing and maintaining the network, the MCO must consider:

a. Its anticipated Medicaid enrollment.

b. The expected utilization of services, as well as the characteristics and health care needs of specific Medicaid populations enrolled in the MCO.

c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.

d. The numbers of network providers who/that are not accepting new Medicaid patients.

e. The geographic location of providers and members, considering distance, travel time, the mode of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

f. Members with special health care needs, including individuals with disabilities. The MCO should identify providers with experience and competency providing primary and other specialty care services to individuals with adult-onset and developmental disabilities.

7. Patient-Centeredness/Patient-Centered Medical Homes

a. The MCO must promote and facilitate the capacity of its providers to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Patients must be active participants in their own health and well-being; they must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute, and chronic needs of members, using the best available evidence and appropriate technology. The MCO's implementation of PCMHs must be inclusive of pediatric practices. Minimum standards for Patient Centered Medical Homes are listed in Attachment 4 – Patient-Centered Medical Home Standards.

b. Requirements of a PCMH include:

i. Providing comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited to, electronic contacts and ongoing care coordination and health maintenance tracking.

ii. Providing primary health care services for members and appropriate referral to other health care professionals or health professionals with structured follow-up.

iii. Planning and coordinating activities to prevent illness and disease.

iv. Encouraging active participation by a member and his/her family, guardian, or authorized representative, when appropriate, in health care decision-making and care plan development.

v. Facilitating the partnership between members, their PCP, and when appropriate, the member's family.

vi. Encouraging the use of specialty care services and supports.

vii. Providing enhanced access to care outside normal business hours of operation.

viii. Facilitating open scheduling and same-day appointments where possible.

c. The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.

d. The MCO must manage its behavioral health provider network to integrate with other programs and services members receive to promote their recovery, empowerment, and the use of their and their families' strengths, when appropriate, to achieve members' clinical goals and health outcomes. The MCO must work with its providers to coordinate with the following formal and informal resources and programs:

i. Rehabilitation programs that promote and provide skill-building, community support, supported employment and full competitive employment for members.

ii. Recovery support services.

iii. Natural community supports for members and their families.

iv. Anonymous recovery programs (e.g., 12-step programs) for members and their families.

e. The MCO must describe in its response to the RFP, and provide a final PCMH Implementation Plan within 90 calendar days of the date of this contract that also describes, its methodology for promoting patient centeredness/PCMHs within its provider network. The plan should include, but not be limited to:

i. Provision of technology assistance to assist providers in the implementation of patient centeredness, including, but not limited to, electronic health record funding.

ii. Any payment methodology, such as incentive payments, to PCPs to support this transformation.

iii. Provision of technical assistance to assist the PCP's transformation to PCMH recognition (including education, training tools, and data relevant to member clinical care management).

iv. Facilitation of specialty provider network access and coordination to support patient centeredness.

v. Efforts to increase and support the provision of appropriate basic behavioral services in the primary care setting, as well as coordination of services with specialty behavioral health providers and other community services.

vi. Facilitation of data interchange among PCPs, specialists, laboratories, pharmacies, and other appropriate providers.

vii. A methodology for evaluating the level of provider participation and the health outcomes achieved. MLTC will work with the MCOs to develop a common evaluation methodology. The findings from these evaluations shall be included in the MCO's annual quality evaluation report.

8. Pharmacy Network

a. The MCO must accept into its network any pharmacy or pharmacist participating in the Medicaid program provided the pharmacy or pharmacist is licensed and in good standing with MLTC and accepts the terms and conditions of the contract offered to them by the MCO.

b. The MCO or its contracted PBM must obtain active agreement from a participating pharmacy provider prior to the start of services under this contract for that pharmacist to be considered a network provider, even if that pharmacy has an existing relationship for non-Medicaid services with that MCO or its PBM. The pharmacy provider must agree to the terms of the MCO's PBM contract addendum for the Nebraska Medicaid program.

c. The MCO may contract with specialty pharmacies to the extent the MCO determines is necessary to ensure the adequate availability of specialty drugs. The MCO may limit distribution of specialty drugs to a network of pharmacies that meet reasonable requirements to distribute specialty drugs. The MCO may not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the MCO's agreement with its specialty pharmacies. If the MCO maintains a list of designated specialty drugs, the MCO must submit it to MLTC for review and written approval a minimum of 45

MCO's risk score, reflecting the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population.

b. To establish risk-adjusted rates, MLTC's actuary will analyze the risk profile of members enrolled in each MCO using a national risk-adjustment model specified by MLTC.

i. Each member will be assigned to risk categories based on his/her age, gender, and disease conditions. This information and the relative cost associated with each risk category will reflect the anticipated utilization of health care services relative to the overall population.

ii. The relative costs will be developed using State historical data from Medicaid FFS claims and MCO encounter data, as determined appropriate by MLTC's actuary.

c. Risk adjustment will be completed 60 calendar days after the end of each contract year and reviewed semi-annually. Risk adjustment may be completed more than semi-annually if MLTC determines it is warranted.

d. MLTC will provide the MCO with three months advance notice of any major revision to the risk-adjustment methodology. The MCO must provide any input regarding the proposed changes, if at all, within 14 days. MLTC will consider the feedback from the MCOs when making changes to the risk adjustment methodology.

9. Risk Corridor

a. Annual MCO profits or losses must not exceed 3% per year.

b. Profits and losses are calculated by MLTC's actuary as a percentage of the aggregate of all qualifying revenue by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract.

c. The risk corridor calculation must be completed within nine months of the end of the contract year based on the formula below. These calculations ignore revenue taxes, non-operating income, and any forfeited hold-back. The earned hold-back from the prior year is not treated as income in the risk corridor calculation.

Risk corridor profit/loss = qualifying revenue
- MLR rebate
- Net qualified medical expenses calculated for the ~~MLR~~ risk corridor
- Total allowed administration calculated for the administrative cap.

d. If the risk corridor calculation referenced immediately above produces a profit above 3%, the MCO must ensure that the amount over 3% is deposited in the reinvestment account, as described in this section, within nine months of the end of each contract year.

e. The MCO must provide a full financial statement and additional data as requested to MLTC and its actuary to support the risk corridor calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited funds will be returned to the MCO for deposit back into the reinvestment distribution account.

f. If the risk corridor calculation produces a loss of more than 3%, MLTC will pay the MCO an amount equal to the loss above that amount.

g. There will be no risk corridor payment by either party if the risk corridor calculation produces an amount between a three percent gain and a three percent loss.

h. Regardless of the risk corridor calculation, the MCO is eligible to receive its earned hold-back.

10. MLTC Quality Performance Program

a. The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat.

§71-831 and any successor statutes. Neb. Rev. Stat. 71-831 is provided as Attachment 13 – Neb. Rev. Stat. 71-831.

b. Pursuant to Neb. Rev. Stat. §71-831, the MCO must hold back 1.5% of the aggregate of all income and revenue earned by the MCO and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the MCO to earn via the quality performance program.

c. QPP measures for which the MCO is eligible to earn hold-back funds are included in Attachment 14 – Quality Performance Program Measures – Contract Year One.

d. The MCO must report its performance measures that affect the MCO's eligibility to earn hold-back funds monthly, quarterly, and annually.

e. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within six (6) months after the end of each contract year.

f. All earned hold-back funds become the property of the MCO.

g. The MCO must deposit unearned (forfeited) hold-back funds into the reinvestment account to be forfeited to MLTC. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited hold-back funds will be retained by MLTC.

h. No interest will be due to either party on hold-back funds retained by the MCO or returned to MLTC.

i. MLTC reserves the right to modify annually the measures and criteria for earning the hold-back funds. In the event MLTC modifies the measures or criteria, MLTC will provide the MCO 60 calendar days advance written notice. These measures will include operational or administrative measures that reflect MCO business processes and may lead to improved access to and quality of care, CMS Medicaid Adult and Child Core Measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement as indicated by HERITAGE HEALTH historical performance.

j. Any earned hold-back will not be included in the MCO's income for the year nor considered part of the medical loss ratio (MLR) calculation.

11. State Performance Penalties

a. Pursuant to Neb. Rev. Stat. §71-831, 0.25% of the aggregate of all income and revenue earned by the MCO and related parties under the contract must be at risk as a penalty if the MCO fails to meet minimum performance metrics. MLTC will provide minimum performance metrics to the MCO prior to year two (2) of the contract.

b. The MCO must report its performance on the minimum performance metrics monthly, quarterly, and annually.

c. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess annually the MCO's performance compared with the minimum performance metrics and notify the MCO of the amount of liquidated damages due to MLTC. MLTC will make this determination within six (6) months after the end of each contract year.

d. MLTC reserves the right to modify the minimum performance metrics and criteria for assessing liquidated damages annually. In the event MLTC modifies the metrics or criteria, MLTC will provide the MCO 60 calendar days advance written notice.

12. Administrative Cap

a. Per Neb. Rev. Stat. §71-831, 68-908, and 71-801 (2012), the MCO's administrative spending must not exceed 7%, except up to an additional 3% is allowed, if the additional amount is for the purpose of quality improvement and approved by MLTC.

b. The MCO's total administrative spending must not under any circumstance exceed 10%. The total allowable administrative expense rate is the lesser of 10% and the total of allowable QI and non-QI administrative expenses, less any related-party administrative margin.

c. With its quarterly financial report, the MCO must provide to MLTC a detailed accounting of administrative expenses, including allowable QI expense.

d. To ensure compliance with the State law, MLTC will calculate the administrative expense rate within nine months of the end of each contract year.

e. Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation.

13. Medical Loss Ratio

The MCO must provide an annual Medical Loss Ratio (MLR) report to MLTC, in a form, manner, and pursuant to a timeline prescribed by MLTC. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than 85%, the MCO must refund MLTC the difference. (See Attachment 15 – Medical Loss Ratio Requirements for the MLR calculation methodology and classification of costs.)

14. Reinvestment Accounts

a. Pursuant to Neb. Rev. Stat. §71-831, the MCO must provide for the reinvestment of profits in excess of the contracted amount, performance contingencies imposed by the department, and any unearned (forfeited) hold-back funds. To this end, the MCO must establish and manage two accounts:

i. A hold-back account, for the purpose of holding funds listed in the QPP. Funds in this account include both the Federal and State share of cost in the State's Medicaid program.

ii. A reinvestment account, for the purpose of holding funds pursuant to Neb. Rev. Stat. §71-831 after the federal share of cost has been returned to MLTC.

b. Both the holding and reinvestment distribution accounts must:

i. Be separate from other accounts required by the contract, or that may be required by State or Federal law.

ii. Have no risk-bearing investments.

iii. Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. §30-3801 to 30-38110).

c. The MCO must use funds in the reinvestment distribution account in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

d. The MCO must develop, with input from MLTC and its stakeholders, a plan for expenditure of funds in the reinvestment distribution account, for approval by MLTC. The MCO must submit a report to MLTC describing implementation of the plan and evaluating the impact of an approved plan within 90 calendar days of the end of each contract year.

e. The MCO must ensure that:

i. The annual financial reporting package as describe in this section is submitted by the MCO within six (6) months of the end of each contract year.

ii. Upon written approval of the annual financial reporting package by MLTC, the MCO must transfer to the State all funds held in the reinvestment holding account.

~~under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.~~ Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.

Primary care services: All health care services and laboratory services customarily furnished by or through primary care provider ~~a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician~~, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under a contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information that if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Protest: A complaint about a governmental action or decision related to an Invitation to Bid or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency under the FFS model, or for the managed care program, any individual or entity who/that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Qualifying revenue (for the risk corridor calculation): The aggregate of revenue earned by a MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. Any earned hold-back is not factored into the calculation.

Qualifying revenue (for the administrative cap calculation): The aggregate of revenue earned by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignoring federal and state premium taxes and non-operating income. The hold-back (earned and forfeited) is factored into the calculation.

Quality improvement (QI) administrative rate: Equals the QI Expenses divided by Qualifying Revenue.

Quality improvement (QI) expenses: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as:

1. Effective case management, Care coordination, and Chronic Disease Management, including:
    - **a.** Patient centered intervention such as:
        - i. Making/verifying appointments;
        - ii. Medication and care compliance initiatives;
        - iii. Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
        - iv. Programs to support shared decision making with patients, their families and the patient's representatives;
        - v. Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers;
        - vi. Incorporating feedback from the insured to effectively monitor compliance;

vii. Providing coaching or other support to encourage compliance with evidence based medicine;
viii. Activities to identify and encourage evidence based medicine;
ix. Activities to prevent avoidable hospital admissions;
x. Education and participation in self-management programs; and
xi. Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance.

b. Improve patient safety;
c. Wellness and health promotion activities;
d. Health Information Technology (HIT) expenses related to Quality Improvement Activities:
i. Data extraction, analysis and transmission in support of the activities described above; and
ii. Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care.

2. The following items are broadly excluded as not meeting the definitions above:
a. All retrospective and concurrent Utilization Review;
b. Fraud Prevention activities;
c. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
d. Provider Credentialing;
e. Marketing expenses;
f. All Accreditation Fees;
g. Costs associated with establishing or maintaining a claims adjudication system;
h. Costs associated with calculating and administering individual enrollee or employee incentives; and
i. Any function or activity not expressly listed as approved.

Quality management: The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services. Maintaining established guidelines and standards reflective of the current state of physical and behavioral health knowledge.

Readiness review: MLTC's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure, operational protocols, MCO standards, and MCO systems. This review may be done as a desk review, on-site review, or combination and may include interviews with pertinent MCO personnel.

Re-enrollment: The process by which the State automatically re-assigns a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO.

Reinsurance: An insurance product, also known as stop-loss insurance, risk control, or excess insurance, which provides protection against catastrophic or unpredictable losses. An MCO may purchase reinsurance to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Reinvestment account: The account a MCO must establish for any profits in excess of the contracted amount, performance contingencies imposed by MLTC, and any unearned hold-back funds, pursuant to Neb. Rev. Stat. §71-831-.

Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract.

Related-party administrative expense: ~~Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.~~ Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related-party for administrative costs actually incurred by the related party in connection with the administration of the contract.

Related-party administrative margin: Related-party administrative expense divided by qualifying revenue.

Related party medical margin: The difference between medical costs incurred, including a related-party relationship and those incurred in the absence of a related-party arrangement. An arrangement whereby a MCO pays a related party a sub-capitation. For example, because Medicaid medical expenses must reflect the costs that would have been incurred in the absence of any related-party relationship, the circumstance in which a MCO pays any related party a sub-capitation would necessitate calculation of the related party medical margin.

ii. For all reports, 15 calendar days from the date of discovery by the MCO or date of written notification by MLTC (whichever is earlier). MLTC may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can demonstrate to MLTC's satisfaction that the problem cannot be corrected in 15 calendar days.

b. Failure of the MCO to respond within these timeframes may result in penalties per Section IV V Contract Non-Compliance..

10. Reporting Dashboard

a. The MCO must work with MLTC to develop a reporting dashboard. The purpose of this dashboard is to provide MCO and MLTC leadership with easily accessible MCO results related to access to and quality of care, as well as program cost-effectiveness. Access to this dashboard will be determined in consultation with MLTC. The dashboard must be operational within six months after the contract start date. The dashboard will augment, but not replace, other reporting templates required by MLTC. At its sole discretion, MLTC may determine that reports generated by this dashboard are sufficient and may no longer require the MCO to complete similar or other reports. Dashboards must be updated within the timelines specified by MLTC. The reporting dashboard must include, at a minimum, statistics related to:

i. Member enrollment.

ii. Call center statistics.

iii. Status of credentialing applications.

iv. Performance measures.

v. Care management.

vi. Pending grievances and appeals.

vii. Pending claims.

viii. Financial status.

ix. Any other issues as identified by MLTC.

b. MLTC reserves the right to require MCO participation in an alternative reporting and dashboard system at its discretion.

U. CONTRACT MONITORING

1. MCO Policies and Procedures

MLTC will provide the MCO with updates to attachments; other information; interpretation of all pertinent State and/or Federal Medicaid regulations; and, MCO policies, procedures, and guidelines affecting the provision of services under this contract. The MCO will submit written requests to MLTC for additional clarification, interpretation, or other information, as appropriate. Provision of this information does not relieve the MCO of its obligation to keep informed of applicable State and Federal laws related to its obligations under this contract.

2. Operational Reviews

a. In accordance with CMS requirements (42 CFR 438.204), MLTC, or its designee, will conduct periodic operational reviews to ensure program compliance and identify best practices. The reviews will identify and make recommendations for areas of improvement, monitor the MCO's progress towards implementing mandated programs or operational enhancements, and provide the MCO with technical assistance when necessary. The type and duration of the review will be solely at MLTC's discretion.

b. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish this information to MLTC with its proposal to this RFP or whenever it adopts the policy during the term of the contract. The information provided must be consistent with the requirements of 42 CFR 438.10. The MCO's members and potential members must be informed of this policy before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service.

c. If the MCO elects to not provide, reimburse for, or provide coverage of a counseling or referral service, the MCO must inform the member where and how to access the covered service.

D. STAFFING REQUIREMENTS

1. General Requirements

a. The MCO must have in place organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The MCO must be staffed by qualified persons in numbers appropriate to the MCO's enrollment.

b. For the purposes of this contract, the MCO must not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), and 42 CFR 1003.102(a)(2)]. The MCO must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs. The Federal DHHS Office of Inspector General website, which can be searched by the name of any individual, can be accessed at: https://oig.hhs.gov/exclusions/index.asp.

c. The MCO must employ sufficient staff and utilize appropriate resources to achieve contractual compliance. The MCO's resource allocation must be adequate to achieve required outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and MLTC policy requirements, including the requirement for providing culturally competent services. If the MCO does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by MLTC, including but not limited to, requiring the MCO to hire additional staff and application of monetary penalties as specified in this RFP.

d. The MCO must perform criminal background checks on all employees of the MCO and subcontractor staff assigned to, or proposed to be assigned to, any aspect of this contract and who have access to electronic protected health information on Medicaid applicants and recipients. The MCO must, upon request, provide MLTC with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for these MCO staff or subcontractor staff.

e. The MCO will be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the State.

f. The MCO must remove or reassign, upon written request from MLTC, any MCO employee or subcontractor's employee that MLTC deems at its sole discretion to be unacceptable. The MCO must hold MLTC harmless for actions taken as a result hereto.

2. Key Staff Positions

a. The MCO must comply with minimum key staffing requirements in Table 1 listed below.

i. For each key staff position marked with an asterisk in the table, the staff member must be based in the State.

ii. All positions listed in the table must be full-time, i.e. a minimum of 40 hours per week, with the exception of the Business Continuity Planning and Emergency Coordinator, which shall be an additional duty assignment.

b. An individual staff member may not occupy more than two (2) key staff positions listed below unless prior approval is obtained from MLTC. Exceptions include the Chief Executive Officer (CEO) and Medical Director (MD), who may only hold one (1) position.

c. A minimum of 45 calendar days prior to the contract start date, the MCO must submit to MLTC for review and approval a Human Resources and Staffing Plan. This plan must describe how the MCO will obtain and maintain the staffing level needed to accomplish the duties outlined in this RFP. The MCO is required to recruit, hire, train, supervise, and, if necessary, terminate, such professional and support personnel as are necessary to carry out the terms of this contract. All staff must have experience and expertise in working with the populations served by the Medicaid program.

d. The MCO must provide to MLTC, in writing, a list of all officers and members of the MCO's Board of Directors. This information must be provided to MLTC prior to the contract's start date. The MCO must notify MLTC, in writing, within ten (10) business days of any change to its officers or Board members.

e. The MCO must submit to MLTC the names, resumes, and contact information for all key staff listed below a minimum of 30 calendar days prior to the contract's start date.

f. In the event of a change of any key staff at any point during the contract's duration, the MCO must notify MLTC in writing within two business days of the change. The name of the interim contact person shall be included with this notification.

g. The MCO must replace any key staff member with a person of equivalent experience, knowledge, and talent. The name and resume of the new employee must be submitted to MLTC as soon as the new hire is made, along with a revised organizational chart complete with key staff time allocation to the MLTC contract.

h. Replacement of the CEO or MD requires prior written approval from MLTC. This approval will not be unreasonably withheld, provided a suitable candidate is proposed.

i. In addition to the key staff requirements, the MCO must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; utilization management; quality management and improvement; and, member services, education, and outreach, grievances and appeals, provider services, claims processing, and reporting.

Table 1. Key Staff

Title	Minimum Duties
Chief Executive Officer (CEO)*	The CEO must work full-time on this contract, a minimum of 40 hours per week. The CEO is responsible for: 1. Providing overall direction and prioritization for the MCO. 2. Developing and carrying out leadership strategies. 3. Ensuring that policies and contractual requirements are followed. 4. Providing operational oversight to ensure that goals are met. 5. Developing and implementing integration models that ensure coordination with system partners.

Title	Minimum Duties
Medical Director/Chief Medical Officer*	The Medical Director must be a currently practicing physician, with an unrestricted license in the State to practice medicine. The Medical Director must have a minimum of three (3) years of training in a medical specialty and five (5) years of experience providing clinical services. The Medical Director must devote a minimum of 40 hours per week to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director must be board certified in his/her specialty, and be actively involved in all major clinical, utilization management and quality management decisions of the MCO. When the Medical Director is unavailable, the MCO must have a physician staff person or subcontractor to provide competent medical direction at any time. The Medical Director is responsible for: 1. Developing, implementing, and interpreting medical policies and procedures. Duties may include, but are not limited to: service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals. 2. Administrating the medical management activities of the MCO. 3. Participating via telephone or in person (at MLTC's discretion) at every Quality meeting with MLTC and other system partners, and as requested by MLTC. 4. Leading the Utilization Management, Quality Assessment and Performance Improvement, Credentialing, and Provider Advisory committees.
Behavioral Health Clinical Director	The Behavioral Health Clinical Director must be a currently practicing psychiatrist or psychologist with an unrestricted license in the State. The Behavioral Health Clinical Director must have a minimum of five years of combined clinical experience in mental health and substance use disorder services and be knowledgeable about primary care/behavioral health integration. This individual must oversee and be responsible for all behavioral health activities within the MCO and take an active role in the MCO's medical management team, and in clinical and policy decisions. The Behavioral Health Clinical Director is responsible for: 1. Providing clinical case management consultations and clinical guidance for contracted PCPs treating behavioral health-related concerns not requiring referral to behavioral health specialists. 2. Developing comprehensive care management programs for youth and adults with behavioral health concerns, typically treated by PCPs, such as ADHD and depression; 3. Developing targeted education and training for the MCO's PCPs that commonly encounter behavioral health issues.
Behavioral Health Manager*	The Behavioral Health Manager must be a Nebraska licensed behavioral health professional, such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist, or mental health counselor. The responsibilities of the Behavioral Health Manager include, but are not limited to: 1. Ensuring that the MCO's behavioral health operations, providers, and any subcontractors are in compliance with the terms of this contract. 2. Coordinating all areas of the MCO, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting.
Chief Operating Officer (COO)*	The COO is responsible for: 1. Managing the day-to-day operations of the MCO's departments, staff, and functions to ensure that performance measures and MLTC and Federal requirements are met. 2. May serve as the primary contact with MLTC for all MCO operational issues.
Chief Financial Officer (CFO)*	The CFO is responsible for overseeing all financial-related supervision of activities implemented by the MCO, including all audit activities, accounting systems, financial reporting, and budgeting.

Title	Minimum Duties
Program Integrity Officer*	The Program Integrity Officer must have experience in health care and/or risk management and report directly to the CEO. The Program Integrity Officer is responsible for: 1. Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program. 2. Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. 3. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans. 4. Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies. 5. Managing the MCO's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit.
Grievance System Manager*	The Grievance System Manager is responsible for: 1. Managing/adjudicating member grievances, appeals, and requests for fair hearing. 2. Managing/adjudicating provider grievances and appeals.
Business Continuity Planning and Emergency Coordinator	The Business Continuity Planning and Emergency Coordinator is responsible for: 1. Ensuring continuity of benefits and services for members who may experience evacuation to other areas of the State, or out-of-state, during disasters. 2. Managing and overseeing the MCO's emergency management plan.
Contract Compliance Coordinator*	The Contract Compliance Coordinator will be the primary contact with MLTC on all MCO contract compliance issues. This individual is responsible for: 1. Coordinating the preparation and execution of contract requirements. 2. Coordinating the tracking and submission of all contract deliverables. 3. Answering inquiries from MLTC. 4. Coordinating/performing random and periodic audits and ad hoc visits.
Quality Management (QM) Coordinator*	The QM Coordinator must be a State-licensed registered nurse, physician, or physician's assistant; a Certified Professional in Health Care Quality (CPHQ), certified by the National Association for Health Care Quality, or certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. This position must be committed to this contract on a full-time basis (a minimum of 40 hours per week). The QM Coordinator must have quality management and improvement experience as described in 42 CFR 438.200 - 438.242. This individual is responsible for: 1. Ensuring systemic and individual quality of care. 2. Identifying and implementing process improvements. 3. Integrating quality throughout the organization. 4. Ensuring a network of credentialed providers. 5. Resolving, tracking, and trending quality of care grievances. 6. Serving as a member of the Quality Assurance Performance Improvement Committee and member/ad hoc member of other quality related committees.
Performance and Quality Improvement Coordinator*	The Performance and Quality Improvement Coordinator must, at minimum, be a CPHQ or CHCQM or have comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200 - 438.242. The Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include: 1. Focusing organizational efforts on the improvement of clinical quality performance measures. 2. Utilizing data to develop intervention strategies to improve outcomes. 3. Developing and implementing performance improvement projects, both internal and across MCOs. 4. Reporting quality improvement and performance outcomes to MLTC.

Title	Minimum Duties
Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator*	The MCH/EPSDT Coordinator must be a current, Nebraska-licensed registered nurse, physician, or physician's assistant; have a Master's degree in health services, public health, or health care administration, or other related field; or be a CPHQ or CHCQM. Staffing under this position must be sufficient to meet quality and performance measure goals. The coordinator is responsible for: 1. Designing programs to ensure that all member children receive necessary EPSDT services. 2. Promoting family planning services. 3. Promoting preventive health strategies. 4. Designing programs to ensure that all pregnant members receive maternal and postpartum care. 5. Identifying and coordinating assistance for identified member needs, specific to maternal/child health and EPSDT. 6. Interfacing with community partners.
Medical Management Coordinator*	The Medical Management Coordinator must be a State-licensed registered nurse, physician, or physician's assistant if he/she is required to make medical necessity determinations. If the position is not required to make medical necessity determinations, this individual may have a Master's degree in health services, health care administration, or business administration. The Medical Management Coordinator's responsibilities include: 1. Developing, implementing, and monitoring the provision of care coordination, disease management, and case management functions. 2. Ensuring the adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria. 3. Ensuring the completion of appropriate concurrent review and discharge planning of inpatient stays. 4. Monitoring, analyzing, and implementing appropriate interventions based on utilization data, including the identification and correction of over- or under-utilization of services. 5. Monitoring prior authorization functions and ensuring that decisions are made in a consistent manner, based on clinical criteria, and that all decisions meet timeliness standards.
Provider Services Manager*	The Provider Services Manager is responsible for: 1. Coordinating communications between the MCO and its subcontracted providers. 2. Managing the Provider Services staff. 3. Working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns. 4. Developing provider trainings in response to identified needs or changes in protocols, processes, and forms. 5. Enhancing MCO-provider communication strategies. 6. Notifying MLTC of correspondence sent to providers for informational and training purposes. 7. Participating in the MLTC Administrative Simplification Committee.
Member Services Manager*	The Member Services Manager is responsible for: 1. Coordinating communications between the MCO and its members. 2. Ensuring there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program. 3. Managing the Member Services staff.

Title	Minimum Duties
Claims Administrator	The Claims Administrator is responsible for: 1. Developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with State and Federal requirements and the terms of this contract. 2. Developing cost avoidance processes. 3. Meeting claims processing timelines. 4. Ensuring minimization of claims recoupments. 5. Meeting MLTC encounter reporting requirements.
Provider Claims Educator	This position must be knowledgeable concerning the MCO's Nebraska Medicaid Managed Care grievance, claims processing, and provider services systems and facilitate the exchange of information between these systems and providers. This individual must have a minimum of five (5) years management and supervisory experience in a health care field. The Provider Claims Educator is responsible for: 1. Educating in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available MCO resources, such as provider manuals, websites, provider training materials, and fee schedules. 2. Communicating frequently with providers to ensure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices. 3. Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction. 4. Working with the MCO's call center to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements.
Case Management Administrator*	The Case Management Administrator should have experience as a case manager with a minimum of five (5) years management or supervisory experience in a health care field. The position is responsible for: 1. Overseeing the MCO’s case management functions. 2. Working with other MCO staff to ensure that members’ case management needs are met. 3. Working with the Medical Director and other medical management staff to ensure that the MCO has case management policies/protocols that comply with Federal and State requirements.
Information Management and Systems Director	The Information Management and Systems Director must have relevant training and a minimum of seven (7) years of experience in information systems, data processing, and data reporting to oversee all MCO information systems functions. The position is responsible for: 1. Establishing and maintaining connectivity with MLTC information systems. 2. Providing necessary and timely data and reports to MLTC.
Encounter Data Quality Coordinator	The Encounter Data Quality Coordinator is responsible for: 1. Organizing and coordinating services and communication between MCO administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues. 2. Serving as the MCO's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions. 3. Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
Tribal Network Liaison*	The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all MCO staff on American Indian issues and concerns.

Title	Minimum Duties
	3. Advocating for American Indian members with case management and member services staff.
Pharmacist/Pharmacy Director*	The MCO Pharmacist/Pharmacy Director must be a registered pharmacist with a current State license. The incumbent must have a minimum of three (3) years of experience supporting formularies, designing prior authorization requirements, and working with clinical information. The Pharmacist/Pharmacy Director is responsible for: 1. Overseeing the prescription drug and pharmacy benefits. 2. Leading and coordinating formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving. 3. Consulting on and coordinating pharmacy program changes. 4. Understanding clinical pharmacy and drug product information to support plan benefit design in the point of sale system. 5. Overseeing, monitoring, and assisting with the management of pharmacy benefit manager (PBM) activities. 6. Managing the prospective and retrospective drug utilization review (DUR) activities. 7. Supporting call center prior authorization programs and their development/modification. 8. Attending MLTC Pharmacy and Therapeutics Committee and DUR Board meetings. 9. Meeting with MLTC staff and the MCO's PBM, no less than monthly, to discuss operational status updates, including the call center, POS system, grievances, and prior authorizations; and review performance standards and restricted services grievances and appeals.

3. Additional Required Staff

a. Prior authorization staff must include a State-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a State-licensed registered nurse or physician's assistant) to authorize health care services (in compliance with contract requirements), at any time.

b. Concurrent review staff must include a State-licensed registered nurse or physician's assistant. Staff must work under the direction of the Medical Director or the Medical Management Coordinator (if this person is a State-licensed registered nurse or physician's assistant) to conduct inpatient concurrent reviews.

c. Clerical and support staff to ensure the proper functioning of the MCO's operation.

d. Provider services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the MCO program. There must be sufficient staff to maintain/enhance the MCO's provider network to meet MLTC's network standards and work with grievances and appeals staff to resolve provider grievances and disputes on a timely basis. The MCO must designate a local individual to serve as a liaison for behavioral health providers.

e. Member services staff to enable members to receive prompt responses and assistance. There must be sufficient member services staff at all times to provide culturally and linguistically appropriate services.

f. Claims processing staff to ensure the timely and accurate processing/adjudication of original claims and resubmissions. The MCO must have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

g. Encounter processing staff to ensure the timely and accurate processing and submission to MLTC of encounter data and reports.

h. Care management staff to assess, plan, facilitate, and advocate options and services to meet members' health and social needs. The staff must use communication and available resources to

promote quality, cost-effective outcomes. The MCO is required to provide and maintain appropriate levels of care management staff in the State to ensure adequate local geographical coverage for face-to-face contact with physicians and members as appropriate, and may include additional out-of-state staff providing telephone consultation and support.

i. FWA investigative staff to detect and investigate FWA activities. The staff is responsible for preparing and updating the fraud and abuse compliance plan, conducting MCO employee training and monitoring, investigating a sample of paid claim discrepancies, and responding to provider investigation-related inquiries/issues. Each FWA investigator must have a Bachelor's degree; an Associate's degree plus a minimum of two (2) years' experience as a licensed health care provider or auditor; a minimum of four years' experience as a certified coder or billing specialist; or, a minimum of five (5) years law enforcement, health care oversight, compliance, or auditing experience. The MCO must have a minimum of one investigator for every ~~100,000~~ 50,000 members or less.

j. All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff, customer service representatives staffing the toll-free call center, and certain care management staff.

4. Care Management and Utilization Management Staff Requirements

a. As part of its care management operations, the MCO must employ a multidisciplinary clinical staff, care coordinators, and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to members. The MCO must ensure an adequate ratio of staff to members to perform all care management functions as described in Section IV.L Care Management of the RFP. Sufficient staff must be available to respond at any time to members, their families/caregivers, or other interested parties calling on behalf of a member.

b. The MCO must ensure that only licensed clinical staff operating within the scope of their training and professional licenses make decisions regarding medical necessity.

5. Written Policies, Procedures, and Position Descriptions

a. The MCO must develop and maintain written policies, procedures, and position descriptions for each functional area, consistent in format and style. The MCO must have written guidelines for developing, reviewing and approving all policies, procedures, and job descriptions. All policies and procedures must be reviewed at a minimum on an annual basis to ensure that they reflect current practices. Once the policies are reviewed, they must be dated and signed by the MCO's appropriate manager, coordinator, director, or administrator. Minutes reflecting the review and approval of the policies by the appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the MCO's Medical Director. Job descriptions must be reviewed a minimum of annually to ensure that they reflect current duties.

b. Based on provider or member feedback, if MLTC determines that a MCO policy or process is inefficient or places an unnecessary burden on the members or providers, the MCO will be required to work with MLTC to change the policy or procedure within a time period specified by MLTC.

6. Staff Training and Meeting Attendance

a. The MCO must ensure that all staff members, including subcontractors, have training, education, experience, and orientation to complete their job responsibilities. MLTC may require additional staffing for a MCO that has substantially failed to maintain compliance with any provision of the contract and/or MLTC policies.

b. The MCO must provide initial and ongoing staff training that includes an overview of MLTC and its policies, the contract, and State and Federal requirements specific to individual job functions. The MCO must ensure that all staff members who have contact with members or providers receive initial and ongoing training with regard to program changes, prior authorization modifications, and the appropriate identification and handling of quality of care/service concerns.

c. The MCO must educate staff concerning their policies and procedures on advance directives in accordance with 42 CFR 422.128.

d. A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All MCO staff must be trained on how social determinants affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, violence, and risk and protective factors for behavioral health concerns. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

e. The MCO must provide training for staff on the needs of the Long-Term Services and Supports (LTSS) population, including individuals with developmental disabilities and mental health concerns.

f. New and existing prior authorization, provider services, and member services staff must be trained in the geography of the State, as well as the culture and correct pronunciation of cities, towns, and surnames. Appropriate staff must have access to GPS or mapping search engines for the purposes of authorizing services, recommending providers, and transporting members to the most geographically appropriate location.

g. The MCO must provide the appropriate staff representation in meetings or events scheduled by MLTC. All meetings are considered mandatory unless otherwise notified by MLTC.

h. MLTC reserves the right to attend any and all training programs and seminars conducted by the MCO. The MCO must provide MLTC a list of any training dates, times, and locations a minimum of 14 calendar days prior to their occurrence.

E. COVERED SERVICES AND BENEFITS

1. General Provisions

a. The MCO must have available, for members, immediately upon their effective date, at a minimum, those benefits and services specified in the RFP, and as defined in the Nebraska Medicaid State Plan, administrative rules, and MLTC policy and procedures. The MCO must possess the expertise and resources to ensure the delivery of quality health care services to its members in accordance with Nebraska Medicaid program standards and the prevailing local and national medical standards.

b. The MCO must provide a mechanism to reduce inappropriate and duplicative use of health care services, including but not limited to, non-emergent use of hospital emergency rooms.

c. The MCO must ensure the coordination of services it provides with services the member receives from other entities. The MCO must ensure that in the process of coordinating care that each member's privacy is protected in accordance with Federal and State requirements.

d. Services must be rendered by providers that are appropriately licensed or certified, operating within their scopes of practice, and enrolled as a MLTC provider. The MCO must provide the same standard of care for all members, regardless of any member's eligibility category.

e. The MCO must comply with any future legislative and regulatory changes regarding covered services and benefits unless those changes specifically exempt managed care.

2. Amount, Duration and Scope

a. The services offered under the MCO contract must be sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and must be no less than those furnished under FFS Medicaid, as specified in 42 CFR 438.210(a). Upward variances of amount, duration, and scope of these services are allowed.

b. All services covered under this contract must be accessible to MCO members with comparable timeliness, and in a similar amount, duration, and scope as those available to other insured individuals in the same service area.

i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian members who are eligible to receive services from these providers either:

a) At a rate negotiated between the MCO and the I/T/U provider, or

b) If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR 447.45 and 447.46.

b. Additional required Indian health protections are included in Section IV.F Member Services and Education.

5. Psychiatric Residential Treatment Facilities

The MCO's rate of reimbursement for psychiatric residential treatment facilities must be no less than the published Medicaid FFS rate on the date of service.

6. Value-Based Contracting

a. It is the policy of MLTC that HERITAGE HEALTH should promote added value for members and providers. Value is captured through programs that improve outcomes and lower costs. Contracted providers shall be engaged in the pursuit of improved value. A key mechanism to achieve this is through value-based contracting arrangements. For purposes of this contract, value-based contracts are defined as payment and contractual arrangements with providers that include two components:

i. Provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics, and

ii. Payment methodologies that align their financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

b. The MCO must enter into value-based purchasing agreements with 30% of its provider network by the third year of the contract, and 50% of its provider network by the fifth year of the contract.. By the end of the first year of the contract, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing agreements. In its response to this RFP, the MCO shall describe its philosophy regarding value-based purchasing agreements and provide evidence of its effective use in the State or other markets.

c. The MCO must notify MLTC of any risk-sharing agreements it has negotiated with a provider within 15 calendar days of any contract signing with the provider containing this provision. Any provider contract that includes capitation payments must require the submission of encounter data within 90 calendar days of the date of service. As applicable, the provider contracts must comply with the requirements set forth in Section IV.I Provider Network Requirements of this RFP and in compliance with 42 CFR 434.6. The MCO must maintain all provider contracts in compliance with the provisions specified in 42 CFR 438.12 and 42 CFR 438.214, as well as this RFP. MLTC reserves the right to direct the MCO to terminate or modify any provider contract if MLTC determines that the modification or termination is in the best interest of the State.

7. Physician Incentive Plans

a. The MCO's physician incentive plans must meet the requirements of 42 CFR 422.208 and 422.210.

b. A physician incentive plan cannot make a payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member.

c. The MCO must submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of 60 calendar days prior to their intended use. Any provider incentive plan must receive prior MLTC approval. The MCO must disclose the following information in advance to MLTC:

i. Services furnished by physician/groups that are covered by any incentive plan.

ii. Type of incentive arrangement (e.g., withhold, bonus, or capitation).

iii. Percent of withhold or bonus (if applicable).

iv. Panel size, and if patients are pooled, the method used.

v. If the physician/group is at substantial financial risk, documentation that the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss.

d. If the physician/group is put at substantial financial risk for services not provided by the physician/group, the MCO must ensure adequate stop-loss protection for individual physicians and conduct annual member and provider satisfaction surveys.

e. The MCO must provide the information specified in 42 CFR 422.210(b) regarding its physician incentive plan to any Medicaid member on request.

f. If required to conduct member and provider satisfaction surveys (as described in Sections IV.F Member Services and Education and IV.J Provider Services), survey results must be disclosed to MLTC and, on request, to members.

8. Payments to Out-of-Network Providers

a. If the MCO is unable to provide necessary services to a member within its network, the MCO must adequately and timely arrange for the provision of these services out-of-network. In these circumstances, the MCO must ensure that any prior authorization and payment issues are resolved expeditiously.

b. The MCO must ensure that, if applicable, the cost to the member is no greater than it would have been if the services were furnished within the network.

c. For services that do not meet the definition of emergency services, the MCO is not required, unless otherwise provided for in this contract, to reimburse out-of-network providers at more than 90% of the Medicaid rate in effect on the date of service to providers with whom/which it has made a minimum of three (3) documented attempts to contract.

d. The MCO must pay for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the MCO for the provision of these services. The MCO must reimburse emergency service providers 100% of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

e. During the initial 90 calendar days of the contract, the MCO must pay out-of-network providers at 100% of the Medicaid FFS rate, to support member continuity of care.

f. The MCO may require prior authorization for out-of network services, unless those services are required to treat an emergency medical condition.

g. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions. The out-of-network provider must bill the MCO and be reimbursed at no less than the Medicaid rate in effect on the date of service.

h. MCO members shall be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No

Department of Health & Human Services
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NEBRASKA

Division of Medicaid and Long-Term Care

HERITAGE HEALTH

Quality Management Committee Meeting Summary
June 8, 2016

Participants: MLTC Representatives, QMC Members, Public Attendees

Next Meeting: September 15, 2016
1:00 PM to 3:00 PM, Central Time
Nebraska State Office Building
301 Centennial Mall South
Lower Level Room A
Lincoln, NE 68509

Meeting Materials: http://dhhs.ne.gov/medicaid/Pages/med_ManagedCare2.aspx

Overview

- MLTC Director Calder Lynch welcomed Quality Management Committee (QMC) members and thanked members for their willingness to participate in the QMC.
- MLTC Deputy Director Heather Leschinsky led a roll call of QMC members participating in-person and via phone.
- Director Lynch provided an overview of Nebraska Medicaid's current managed care and fee-for-service programs and described how those programs will come together under Heritage Health.
- Director Lynch provided an overview of the procurement process that led to the selection of three health plans for Heritage Health.
- Director Lynch led a review of the QMC Charter and emphasized the importance that quality management will play in improving health outcomes for Medicaid eligible individuals enrolled in Heritage Health.
- Heather Leschinsky briefly described the protocols required for an open public meeting.
- Heather Leschinksy led a review of the quality management-related requirements found in the Heritage Health Request for Proposals (RFP) and the corresponding health plan contracts which can be found on the Heritage Health website at www.dhhs.ne.gov/heritagehealth.
- In addition to the quality management requirements provided to QMC participants and posted on the Heritage Health website prior to the meeting, Heather Leschinsky noted that specific quality performance measures would also be distributed to QMC participants and posted on the Heritage Health website.
- MLTC Administrator for Data & Analystics Aaron Ziska presented the administrative and quality benchmarks currently provided to the Governor and DHHS CEO Courtney Phillips on a monthly basis.
- Nebraska Total Care presented its approach to quality management for Heritage Health. NTC's presentation emphasized its "Quadruple Aim" approach to its Quality Assurance and Performance Improvement (QAPI) program which focuses on the following areas:

- Member Experience
- Population Health
- Cost Savings
- Provider Work Life Balance

- WellCare of Nebraska presented its approach to quality management for Heritage Health. WellCare's presentation emphasized its "Philosophy of Continuous Improvement" which it utilizes to guide development and monitoring of specific activities including:
  - Business Process
  - Interventions
  - Campaigns
  - Initiatives
- UnitedHealthCare Community Plan presented its approach to quality management for Heritage Health. UHC's presentation emphasized its goals of improved member outcomes and enhanced member and provider experience through its three pillar approach which included:
  - Building relationships through compassion
  - Utilizing innovative technology solutions
  - Establishing trust through transparent reporting

Discussion

- Director Lynch opened the meeting for public comments and questions.
- QMC member asked whether the timeframe for provider accreditation will be a topic the QMC will cover.
  - Director Lynch responded that provider accreditation will be a topic covered by the QMC and will be a particular focus for MLTC's Heritage Health Administrative Simplification Committee (ASC).
- QMC member said she was focused on rural health and ensuring adequate access.
  - Director Lynch said that ensuring access was a key component of the QMC and noted that the health plans were required to regularly report on member access to providers and that those reports would be shared with the QMC.
  - Heather Leschinsky added that a related requirement for the health plans is collaboration with other DHHS Divisions' initiatives aimed at improving access to care.
- QMC member asked whether the QMC will be looking at member and provider satisfaction.
  - Director Lynch said that reviewing member and provider satisfaction is a component of the QMC and highlighted the reporting requirements (including areas such as grievances and appeals) for measuring member and provider satisfaction that will be shared with QMC members.
- QMC member asked whether the QMC will address barriers to care.
  - Director Lynch affirmed that identifying and addressing barriers to care will be an important focus of the QMC.
- QMC member asked whether it was an objective of the QMC to identify a single approach to quality management.

    - Director Lynch said that while it was a goal of the QMC and the ASC to identify opportunities to streamline requirements on providers, each health plan is allowed to implement its own quality management program.
- Director Lynch asked that QMC members consider topics they would like to see addressed by the QMC and to assist MLTC and Heritage Health plans in identifying quality-related challenges and opportunities for quality improvement.